

“You cannot change it in a day or night...”

***Female Genital Mutilation/Cutting in the
shanty towns of Port Sudan***



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List of abbreviations

ANC	Antenatal Care
BCC	Behaviour Change Communication
CIA	Central Intelligence Agency
DHS	Demographic and Health Survey
FGC	Female Genital Cutting
FGM/C	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
GTZ	Gesellschaft fuer Technische Zusammenarbeit
HAC	Humanitarian Aid Committee
HIV	Human Immunodeficiency Virus
IAC	Inter African Committee on Traditional Practices Affecting the Health of Women and Children
KAP	Knowledge, Attitude, and Practices
IEC	Information, Education, Communication
LEAP	Learning For Empowerment Against Poverty
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
MSF	Medecins Sans Frontieres
NGO	Non-Governmental Organisation
OCB	Operational Cell Brussels
RSS	Red Sea State
TBA	Traditional Birth Attendant
UNDP	United Nations Development Project
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

Executive Summary

Female Genital Mutilation/Cutting (FGM/C) affects between 100 and 140 million women and girls worldwide. About 3 million girls undergo the procedure every year. FGM/C poses considerable health risks and is associated with severe immediate and long-term complications. A landmark study by Banks et al (2006a) demonstrated that women with FGM/C are significantly more likely to have adverse obstetric outcomes. The recognition of FGM/C as a violation of human rights has led to increased efforts to end the practice. Exploration of the motives for the practice and participation of the stakeholders from the beginning have been considered essential for successful programmes (Mohamud et al, 1999a).

Amongst the Beja in Sudan, the practice of FGM/C is widespread. In Sudan, it is estimated that 89% of women have undergone FGM/C. Of those with FGM/C about 80% show the most severe Type III involving excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (UNICEF, 2006a).

This study is the first that investigated the practice, reasons, and underlying beliefs of FGM/C amongst the Beja living in the shantytowns of Port Sudan. Furthermore, the attitude towards FGM/C was explored, and the opinions and ideas with regard to a future programme. The overall aim was to develop a programme that would empower the community to abandon the practice of FGM/C.

The method was a rapid participatory assessment using a mixed qualitative and quantitative approach. Qualitative data were obtained through focus group discussions and from the open-ended questions of a questionnaire. Quantitative data included questionnaire responses and secondary data collected at a local hospital.

The descriptions of the practice confirmed the mutilating nature of the procedure and the health consequences for girls and women. A high prevalence of FGM/C Type III was confirmed. Data of incidence may indicate a current shift to less invasive forms. Amongst the Beja, FGM/C is not an initiation rite. It is predominantly performed within the first year of life, often as early as in the first week after delivery. Mother and

grandmothers are the main decision makers though men have to give their approval. TBAs and midwives were identified as the main performers. A seasonal variation in the incidence of FGM/C was observed.

Conformity with social convention was the main reason for the continuation of FGM/C. Non-compliance was associated with stigmatisation and a reduced prospect of marriage. FGM/C is also strongly associated with benefits for health: FGM/C is believed to prevent and cure a number of diseases. The Beja seem unique in their health beliefs insofar as the beneficial effects of FGM/C are also perceived in areas unrelated to female reproductive health and sexuality. FGM/C is assumed to offer protection from evil spirits that cause illness, and this could explain why children undergo FGM/C at such a young age. Reasons related to sexuality showed the greatest difference between women and men's responses. Both made assumptions that were not confirmed by the opposite sex. FGM/C with regard to sexuality is rarely discussed between women and men. Other less commonly reported reasons for FGM/C were related to religion, hygiene, and aesthetics.

Assessment of the attitude showed that a substantial number of participants, though still a minority, were against the continuation of FGM/C. Frequently cited reasons were the adverse harmful effects on both the physical and psychological health of the women. Most participants in this study, including the local leaders, stated their interest in a future programme, and their motivation and enthusiasm was reflected in the variety and creativity of their propositions. Many expressed their wish for health education and information on FGM/C. Even some of those who had previously voted for the continuation of FGM/C contributed ideas.

Based on the findings from this study, future strategies should build on those community members who have affirmed their commitment to the discontinuation of FGM/C. These so-called innovators could become leaders in facilitating a dialogue amongst the community that would involve both women and men, and all generations. Discussions should address the misconceptions and misunderstandings with regard to health, sexuality, tradition, and religion with the aim to enable community members to make informed decisions. Specific groups such as older women, parents, or adolescents should

be specifically targeted. Conventional IEC (information, education, communication) activities using various audio-visual media should complement this approach.

Collection of quantitative data should be improved to get a better estimate of prevalence, incidence, and the complications of FGM/C. Additional strategies could include medical and psychological services for women, who have suffered from the consequences of FGM/C. Further qualitative studies could explore the particular beliefs associated with reinfibulation.

1 Introduction/Background with reference to the relevant literature

1.1 Female Genital Mutilation/Cutting (FGM/C)

1.1.1. Definition and terminology

According to World Health Organisation (WHO) Female Genital Mutilation/Cutting has been defined and classified as follows:

“Female Genital Mutilation comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons” (WHO 2000a).

Classification according to WHO (2000b):

- Type I - Excision of the prepuce with or without excision of part or all of the clitoris;
- Type II - Excision of the prepuce and clitoris together with partial or total excision of the labia minora;
- Type III - Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)

Type IV includes any other procedures that fall under the definition of FGM/C.

However, it is not always possible to distinguish clearly between the different types, and other classifications do exist.

The following terms are used in Sudan: Type I excision is called *Sunna* circumcision, or in Arabic "tahir as-sunna" (sunna means the "tradition of the Prophet"). Type III excision is the so-called *Pharaonic Circumcision*, or in Arabic "tahir faronya" (tahir means purification, cleanliness). *Defibulation* is the cutting open of the infibulated labia before or during delivery to allow passage of the fetal head. *Reinfibulation* is the resuturing of the defibulated labia after delivery, and it often involves additional tightening of the introitus to the size before marriage ("El Adel" in Arabic).

The terminology of FGM/C is still under debate, and an international consensus has not been reached. WHO, United Nations and Non-governmental Organisations mostly use

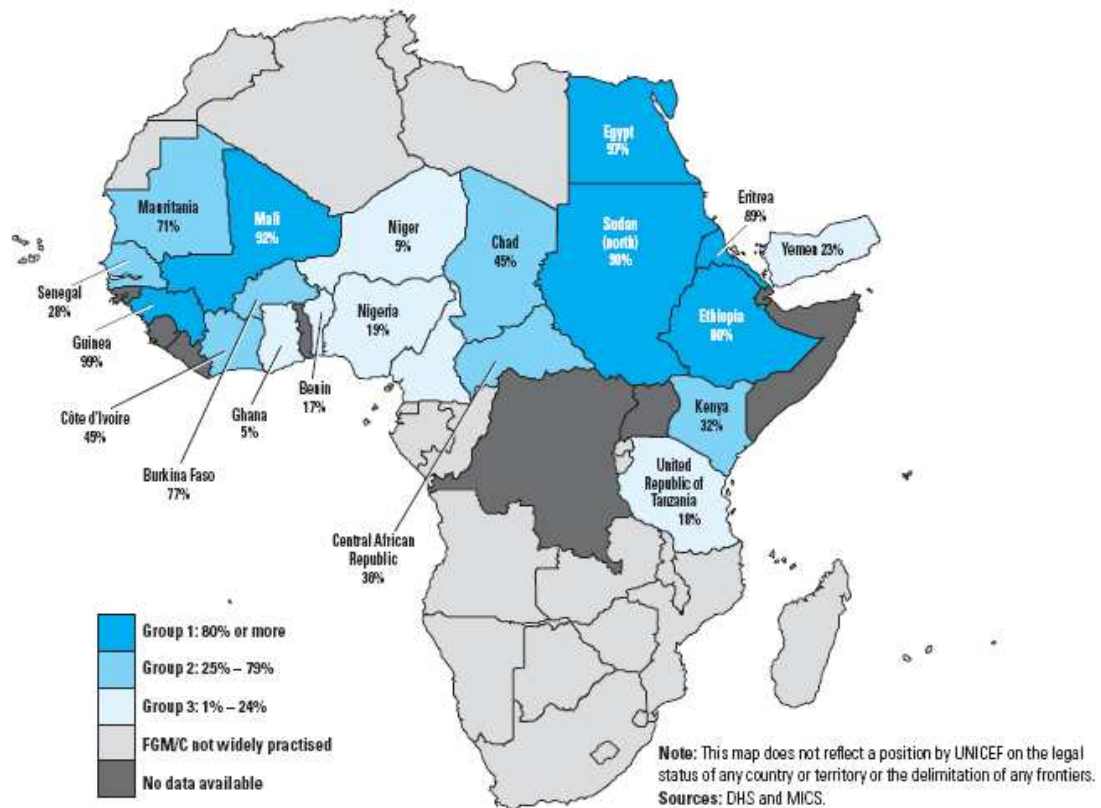
the term Female Genital Mutilation (FGM), to point at the mutilating nature of the procedure and violation of human rights. This term was also adopted at the third conference of the Inter African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) in Addis Ababa in 1991 (Shell-Duncan 2000). It is also most widely used in a scientific context. However, the term "FGM" could be offensive for those who practice FGM/C and do not intend to harm or mutilate. Many women who are circumcised do not consider themselves mutilated. Other terms commonly used include Female Genital Cutting (FGC) and Female Circumcision. Some argue that, strictly speaking, the term "circumcision" refers to the removal of the prepuce of the clitoris, and this is difficult to achieve in young females. It also equals FGM/C with male circumcision (Toubia and Izett 1998, pp.2-3). Some United Nations organisations have started using "Female Genital Mutilation/Cutting" in order "to capture the significance of the term mutilation at the policy level and, at the same time, in recognition of employing non-judgemental terminology with practising communities" (UNICEF 2005a, p.2). In this study, the term FGM/C will be mostly applied but other terminology may appear in the quotations.

1.1.2 Global aspect of FGM/C

Worldwide between 100 and 140 million women and girls suffer from the consequences of Female Genital Mutilation/Cutting (WHO 2000c). It is estimated that about 3 millions girls are cut each year (UNICEF 2005b). Estimates of prevalence are mostly based on data provided by Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), however are not available for all countries.

FGM/C is practiced in 28 countries in Africa (see map), and predominantly in those countries that extend from Senegal in the west to Somalia in the east. However, considerable variations may exist within these countries. Outside the African continent, FGM/C has been reported in communities in Yemen, Jordan, Oman, the Occupied Palaestine Territories, in some Kurdish communities in Iraq, in India, Indonesia, Malaysia (UNICEF 2005c, p3), and in Central and South America. It is also practiced in migrant communities throughout the world (WHO 2000d).

Figure 1: FGM/C prevalence among women aged 15–49



(UNICEF 2005d, p.4)

1.1.3 Origin and historical aspect of FGM/C

Practices of FGM/C have been found throughout history in many cultures, but there is no definitive evidence documenting when or why this ritual began. The origin is thought to predate the rise of Christianity and Islam. Egyptian mummies have been described displaying characteristics of FGM/FGC, and it is thought that FGM/C may have been a sign of distinction amongst the ruling class (Worsley 1938a, pp. 686-691). Herodotus, the Greek historian who travelled around the Mediterranean in the 5th century B. C., reported that the Phoenicians, the Hittites, and the Ethiopians practised circumcision (Taba 1979, p.43). A Greek papyrus from 163 B.C., exhibited in the British Museum in London, refers to the circumcision of a girl in Memphis in Egypt. It seems that circumcision was practiced both by early Romans and by Arabs (Lightfoot-Klein 1989). Strabo, a Greek geographer, described circumcised women along the East Coast of the

Red Sea at about 25 B.C. (Hosken 1993a, p.73). Infibulation has been practiced along the Nile on slave girls, as observed by travellers during the 18th century (Widstrand 1965). It seems that FGM/C was “spread by dominant tribes and civilisations, often as a result of tribal, ethnic, and cultural allegiances” (Toubia 1995a, p.21). FGM/C in the form of clitorrectomy was also practiced in Europe and America in the 19th century as a cure for mental/nervous disease (Sheehan 1981, pp.9-15).

1.1.4 Reasons for FGM/C

The reasons for the practice and the underlying beliefs are multi-faceted and vary from community to community and throughout history. Reasons for FGM/C will be described under the headings as suggested by WHO (2000d):

Psychosexual reasons

In many societies, it is believed that uncircumcised women will not be able to control their sexuality, and “that a girl who is not excised will run wild and disgrace her family” (Hosken 1993b, p.40). Therefore, reduction or elimination of the sensitive tissue will reduce sexual desire in the female. A woman without sexual desire will not seek sexual relations outside marriage, and FGM/C will therefore ensure faithfulness. Circumcision, and especially infibulation, is also seen as proof of chastity and virginity before marriage and will increase a daughter’s marriage prospect (WHO 2000e). FGM/C is also thought to increase men's sexual pleasure (Toubia 1995b).

Sociological reasons

Custom and tradition are commonly given as reasons for FGM/C. It provides identification with the cultural heritage, and it defines who belongs to the group. Toubia suggests that "the fear of losing the psychological, moral, and material benefits of ‘belonging’ is one of the greatest motivators of conformity" (1995c, p. 37). Therefore, it may serve social integration and ensure the maintenance of social cohesion (WHO 2000f).

For some groups, FGM/C is considered as a rite of passage into womanhood. For example, in some societies in West Africa, the clitoris is considered a male part, while

the prepuce of the penis is viewed as female, and “both have to be removed to before a person can be accepted as an adult in his/her sex” (Hosken 1993c, p. 40).

Hygiene and aesthetic reasons

Hygiene and cleanliness are common reasons for FGM/C. In Arabic, the terms used for the procedure are synonymous with those for cleanliness or purification (Hosken 1993d, p 41). Uncircumcised women are regarded as unclean and sometimes not allowed to handle food and water. There is a commonly held view that female external genitalia are ugly (El Dareer 1982, p. 73).

Myths

Many myths are associated with FGM/C. A common belief, e.g. in Ethiopia and Nigeria, is that the clitoris may grow to such a size and length that it may dangle between a woman's legs (Hosken 1993e, p 41; and Lightfoot-Klein 1991a). FGM/C is believed to improve fertility (Toubia 1995c), and to facilitate childbirth (Lightfoot-Klein 1991b). In some communities, it is thought that the clitoris may damage the penis, or that a baby may die when touches it comes in contact with the clitoris (Hosken 1993f, p. 40).

Religious Reasons

FGM/C is practiced across religions including Christians, Jews, Animists, and Muslims. Within Muslim communities, religion is a commonly cited reason for FGM/C. Female circumcision is not mentioned in the Koran. However, a much-disputed reference to it may exist in the Sunna, which is a collection of the words and actions of the Prophet Mohammed. His quote “Do not cut deep; this is enjoyable to the woman and preferable to the man” has stirred up opinions and served as an argument both for and against FGM/C (Abu Sahlieh 1994).

1.1.5 Medical aspects of FGM/C

FGM/C is associated with a vast number of health complications. In their systematic review of the complications of FGM/C, Lovel et al (2000) included 422 published and unpublished papers and reports. As early as 1938, Worsley documented sequelae of FGM/C III observed during seven years as Gynaecologist in Sudan (Worley 1938b). In 1967, Shandall did a cross-sectional clinical study of FGM/C complications of 4024

females in Khartoum (Shandall 1967a). Aziz (1980a) looked at FGM/C complications of 7505 Sudanese women. El Dareer (1983) interviewed 400 women in Khartoum including outcome measures such as “health problems consequent upon FGM/C”.

Short-term complications reported include severe pain, bleeding, damage to adjacent tissues, and urinary retention due to the changes of the anatomical structure. Lack of hygiene during the procedure may result in wound infections, including tetanus (Hosken 1993g, p253), and it has been postulated that FGM/C may increase the transmission of HIV (Monjok et al 2007). Long-term adverse effects include abscesses, inclusion cysts, keloid scars, difficulties with micturition and menstruation, vaginal and pelvic infections, complications in pregnancy and childbirth, and a wide range of psychological and psychosomatic disorders. FGM/C may have an impact on a woman’s sexuality resulting in painful and difficult intercourse (Dareer 1981), and loss of enjoyment and satisfaction (Hosken 1993h, p 253).

Recently, a huge landmark study by WHO, including 28,393 women, demonstrated that women with FGM/C are significantly more likely than those without FGM/C to have adverse obstetric outcomes such as caesarean section, postpartum haemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant, and inpatient perinatal death. The risk of adverse outcomes increases with more extensive FGM/C (Banks et al 2006b).

1.1.6 Human Rights Perspective

The practice of FGM/C contravenes fundamental human rights, including the right to non-discrimination, to integrity of the person and to the highest attainable standard of physical and mental health. A number of international declarations related to international human right laws have condemned FGM/C, or provide a basis to support elimination, e.g. The Universal Declaration of Human Rights, The International Convention on the Elimination of All Forms of Discrimination Against Women, or The Convention of the Rights of the Child. These have been complemented by regional treaties such as the African Charter on Human and People's Rights, the so-called Banjul Charter (Kwateng-Kluytse 2005, pp. 61-71).

It has been debated whether human rights can be applied universally, or whether they are culturally relative. A certain behaviour or culture that seems without sense to one person may have a meaning for those who practice it. Some argue that people have the right to their own culture. The right of people to develop and enjoy their own culture has also been stated in a number of human rights document. However, it has been acknowledged that these have limitations, and that any cultural practices should not infringe upon other human rights (Rahman and Toubia, 2001, p.15-39).

1.1.7 Abolition programmes

Many international and national organizations and agencies, both governmental and nongovernmental, have set up programs to stop or reduce the prevalence of FGM/C. Approaches include IEC (Information, Education, Communication) campaigns that aim at changing attitudes by raising awareness about negative health consequences. Some programmes include teaching about human rights. Others have focused on training and alternative income for excisors, on the introduction of alternative rituals, or on improving anti-FGM/C legislation.

In 1999, WHO commissioned a review of FGM/C programmes in their Mediterranean and Eastern Regions. The researchers evaluated hundreds of programmes according to defined criteria based on effective behaviour change interventions. One of their recommendations, amongst others, was that “Anti-FGM programme implementers must include all stakeholders in the design, implementation, and evaluation of programmes” (Mohamud et al 1999, p 29). UNICEF found that one of the main characteristics of effective programs was that they were participatory and “guide communities to define the problems and solutions for themselves“(UNICEF 2005e, p 35). GTZ (Deutsche Gesellschaft fuer Technische Zusammenarbeit) who has longstanding experience with FGM/C programs recommends that “approaches that look at the context and motives behind the practice in collaboration with the target population, and which also deal with local myths and rumours have proven to be more effective” (GTZ 2001, p.21). In another GTZ publication, Beckmann (2003, p.6) points out that the socio-cultural factors contributing to the continuation of FGM/C may differ from one setting to another. She recommends that any research that was aimed at developing an intervention should use a mixed approach including qualitative methods to gain cultural insight.

1.2 The study context

1.2.1 Geographical, economical and political background

Figure 2: Map of Sudan (CIA 2007)



Sudan is the largest African and Arab country. It borders Egypt to the north, Libya, Chad, Central African Republic, and Democratic Republic of the Congo to the west, Uganda and Kenya to the south, and Eritrea and Somalia to the east. It covers an area of 2.5 million square metres and has about 40 million inhabitants. The official language is Arab. However, there are approximately 600

tribes speaking over 400 different language dialects (Bechtold 1991, p.1). About 70% of Sudanese are Muslim, about 25% follow indigenous beliefs, and 5% are Christians. Sudan's Human Development Index rank is 147th out of 177 countries, and the human Poverty Index rank is 40th out of 102 countries (UNDP 2005). Since its independence in 1956, Sudan has suffered from political instability, characterized by military coups and civil wars.

Port Sudan, where the study took place, is the capital of Red Sea State (RSS) and the second biggest city in Sudan. RSS is located in the northeastern part of Sudan and neighbours Egypt in the north, the Nile State to the west, Kassala State and Eritrea in the south and the Red Sea in the east.

Although the East has much of Sudan's industry in the form of mining, oil refineries and the port in Port Sudan, it is considered one of the poorest regions in Sudan. The majority of the population lives below the poverty line. The central government in Khartoum has been accused of neglect and marginalisation of this semi-desert area, whilst exploiting it

of its natural resources. Red Sea State has experienced recurrent droughts over the past decades. Some of these resulted in severe food crises that have turned RSS into a chronic food deficit area, characterized by regular crop failure. A report by UN (2007) describes a high infant and maternal mortality, high rates of malnutrition, and poor access to safe drinking water and sanitation facilities.

1.2.2 The Beja

The main ethnic group in Eastern Sudan and RSS are the Beja who are originally pastoralists and agro-pastoralists. The droughts forced many to abandon their nomadic lifestyle and look for work in Port Sudan. Many of these economic migrants live in the shanty areas at the edges of the city. While some of the earlier arrivals have built brick homes, the majority lives in shelters made of out of leaves 'mats and wooden poles. Hygiene and sanitation is almost non-existent. There is no system of sewerage or waste management. Water has to be brought into the shanties and is sold from donkey carts.

The Beja live a traditional lifestyle, and they have mostly preserved their original culture and language. There is a strict division between gender roles. Beja society is male orientated. Women usually stay at home and are not involved in any economic activities. A high illiteracy rate and low school enrolment rates, especially for girls, have been reported for Red Sea State (UN 2007).

The Islamic faith of the Beja is combined with "folk beliefs". Pantuliano (2000, p.12) stated that the "combination of Islam and animist elements and the predominance of customary laws over Islamic code are common to all the different Beja groups". The Beja are ruled by traditional values called *silif*. The silif is a "tribal convention and/or customary law that is immensely respected by all members of the community". It regulates all the economic, political, and social aspects of life. These customary rules become mixed with religious values (Sahl et al 2004a, p.6-8).

1.2.3 FGM/C in Sudan

In Sudan, about 89% of women are circumcised according to an analysis of household data from the Demographic and Household Survey (DHS) 1989/1990 and the Multiple

Indicator Cluster Survey (MICS) 2000 by UNICEF (2006b). Unpublished data collected during the DHS 2006 indicate that national prevalence rate of FGM/C practices decreased from 90% to 70% (UNFPA 2007).

It is estimated that, in North Sudan, between 74.1% and 82.3% of circumcised women have undergone Type III, or so-called “Pharaonic” circumcision which involves infibulation (UNICEF 2006c).

Most girls in Sudan are circumcised before their 12th birthday. The majority of circumcisions are performed by traditional birth attendants (UNICEF 2006d).

Activities to eradicate FGM/C started as early as the 1930ies. Sudan was the first African country to introduce legislation against FGM/C, and in 1946, infibulation was prohibited. After independence, in 1956, the law was ratified again but was dropped in 1983. Although there is no legislation to-day, the Sudanese Government has affirmed its commitment towards eradication since the 1990ies (U.S. Department of State 2001a). Parts of the penal code that regulate penalties for injuries are potentially applicable to FGM/C. In 2006, the Ministry of Health has included the elimination of Harmful Traditional Practices, especially FGM/C, as a target in their National strategy for Reproductive Health. (Republic of Sudan, Federal Ministry of Health 2006, p.18)

1.2.4 History and rationale of the study

In 2004, Medecins Sans Frontieres (MSF) undertook two rapid assessments in Port Sudan based on the facts that health indicators in this area had been shown to be some of the worst in the country. The conclusion was that access to health care needed to be improved for the most vulnerable population, living in shanty towns in Port Sudan. MSF decided to support Tagadom Hospital - including Reproductive Health Services- situated within those shanty areas that are mostly populated by the Beja. The Beja community is known for practising Type III circumcision. MSF workers were confronted with the medical complications arising in children after the procedure, and in women attending for antenatal care and deliveries. During deliveries, women with Type III circumcision will need to be cut open, and usually they will be closed or “re-infibulated” again after delivery. However, MSF is “opposed to the practices of any form of FGM/C on the basis

of adverse health consequences of FGM, and the contravention of human rights that FGM/C constitutes” (MSF 1998). Based on this policy, a “Zero tolerance” to re-infibulation was publicly announced. Women were offered safe deliveries that were free-of-charge and would provide all the necessary wound care afterwards. However, it was made clear that they would not be re-infibulated again.

After this announcement, the initial turnout of women accessing the services was very low. This improved slowly after efforts were made to raise awareness in the community through a network of "Home Visitors". The "Home Visitors" are women and men from the Beja community who were initially recruited to collect demographic data from the community. They are each responsible for an area that covers about 400 households. They were further trained to provide basic health education, including information about safe deliveries. However, even if the number of deliveries was increasing it was still lower than expected. It was assumed that women were still re-sutured at home after the delivery in the hospital. MSF decided that the increasing trend for women to deliver at Tagadom merited follow-up with increased service provision and possible operational research into the factors of FGM/C. FGM/C in regard to the Beja had previously been researched in a rural setting (Sahl 2004b). However, it was not known whether the findings could be transferred to the urban shanty setting in Port Sudan.

It was decided to make an assessment of the situation regarding FGM/C in Port Sudan with the purpose to develop effective strategies to empower the community to make informed decisions regarding the practice of Female Genital Mutilation/Cutting. This study was part of the assessment and aims to answer the following question:

What are the beliefs and practices regarding Female Genital Mutilation/Cutting amongst the Beja in the shanty towns of Port Sudan, and their attitude and ideas regarding a programme on FGM/C?

2 Objectives of the study

Overall Objective:

The overall aim of this study is to use the findings to develop effective strategies to empower the community to abandon the practice of Female Genital Mutilation/Cutting.

Specific objectives:

- 1) To identify the practices relating to FGM/C amongst the Beja with regard to procedure, age at the time of performance, type of FGM, estimates of prevalence and incidence, decision structures, and performers
- 2) To explore the underlying beliefs for the practice and continuation of FGM/C amongst the Beja community with regard to rationale, assumed benefits/advantages and gender specific perceptions
- 3) To explore the community's attitude towards FGM/C and their ideas regarding a programme on FGM/C

3 Methods

3.1 Rationale for selection of methods

The study design was the rapid assessment approach using both quantitative and qualitative methods. The method of rapid participatory appraisal was chosen as a way of collecting the information needed for formulating a plan of action (Rifkin and Hughes 1995, p.7). The participatory approach would ensure the involvement of the local community from the beginning. The qualitative method provided a way to explore beliefs, attitudes, and practices through a detailed description. According to Izett and Toubia (1999a, p.48), qualitative studies “can uncover details that could not be captured

by more restrictive quantitative methods and can generate in-depth information that is relevant for the development of appropriate and targeted interventions". However, quantitative methods were included in this study to increase validity.

Methods for data collection were in-depth interviews, focus groups, an interview-administered pilot questionnaire, mapping of the area, observations, and collation of secondary data. Data used for this study were collected in the time between 20th March and 25th April 2007. For the specific purpose of this investigation only part of these data were analysed.

3.2 *Study setting*

3.2.1 Study area

The study area was the shanty towns surrounding Tagadom Hospital in Port Sudan, where MSF has been operational since 2004. They are divided into the areas of Tagadom, Deim Arab, and Onguab which constitute about 25% of all shantytowns in Port Sudan.

The Home Visitors working for MSF had previously mapped the study area. They divided it into 15 sub areas to facilitate their work as follows:

Tagadom, Tagadom A, B1, G1, G2, and Tagadom Shanty, Deim Arab Shanty, Onguab North 1, 2 and 3, Onguab South 1, 2, 3 and 4, and Onguab Shanty.

The affix "shanty" is used for newer, less organised areas but all of the above areas are shantytowns. Each sub area includes approximately 400 households.

3.2.2 Study population

The study population is the Beja community living in the shantytowns of Tagadom, Deim Arab and Onguab in Port Sudan. The majority of Beja women are believed to have undergone Female Genital Mutilation/Cutting Type III.

Total population in study area:	30,891
Total number of children aged <5:	4,353

The figures are means calculated from weekly reports by the MSF Home Visitors between week 42/2006 and week 18 /2007.

Units of analysis are members of the Beja community living in the shantytowns around Tagadom Hospital in Port Sudan and other persons of the Sudanese community that could contribute to the topic such as members of the medical community, or representatives of NGOs.

3.3 Sampling strategies

3.3.1 Selection for the single interviews

Participants for the qualitative part of the study were selected through non-probabilistic purposeful sampling. Specific sampling strategies applied were snowball sampling in which initially identified key informants were asked to suggest other informants. Inclusion criteria were that all respondents should have an interest in FGM/C with regard to the Beja population. However, it was also paid attention to select informants from different types of groups that represent the community, such as leaders/authorities, or community workers. In order to get a broad range of information and views no exclusion criteria were applied.

3.3.2 Selection for the group interviews

Participants for the group interviews were selected through homogenous sampling (selection of similar types of respondents such as women's groups, men's groups), and stratified purposeful sampling (selection of subgroups such as community workers).

3.3.3 Selection for the questionnaire-administered interviews

The female participants for the questionnaire were selected by stratified and selective sampling. The target area had been mapped into 15 sub areas. Each of the 15 sub-areas

was covered by one female researcher. They were instructed to complete 2-3 questionnaires per day on five different days. They were asked to interview the first three women whom they would meet outside their work, and that these women should not be related to each other.

Selective sampling only was applied to the questionnaire interviews with men. The men were interviewed by two male research assistants in the three areas of Deim Arab, Tagadom, and Onguab at markets and mosques. The research assistants were instructed each to interview 3-4 men per day in each area on five different days. They had been instructed to approach the first 3-4 men they would meet in the designated area, and that these men should not be related to each other. The female and male research assistants were all from the Beja community and spoke the local language.

3.3.4 Sample size

1) Interviews and focus groups

In non-probabilistic sampling, the sample size is not pre-determined. Selection of participants will continue until the researcher decides that the point of redundancy has been reached. This means to stop sampling at the point when no further new information will be expected from the participants.

2) Questionnaire

According to Patton (2002), the aim of a questionnaire is not always to generate statistical significance or to be representative but rather to “add credibility when a complete sample is too large to be feasible”. The aim of this questionnaire was to confirm and complement the findings from the interviews on a slightly larger scale. For reasons of feasibility and limitations due to lack of human and financial resources a sample size of 280 was chosen. 180 women and 100 men were interviewed. Based on a population of 30,000, an expected prevalence of 50%, and a confidence level of 95%, the results had a confidence interval of 5.83. These calculations were made using a web-based sample-size calculator (Creative Research Systems 2003).

3.3.5 Instruments

Topic guides and interview guides were developed for the group and single interviews (see Annex 1). The questionnaire was designed together with the female community workers (Home Visitors) and medical staff who were all members of the Beja community. It has a short section for demographic data (location, sex, age). It contains eight questions - five closed and three open questions. The options for the answers of the closed questions either are on a dichotomous scale (yes/no), or offer multiple choices of response categories. The content of the questions relates to reasons for FGM/C, practice of FGM/C, and attitudes towards FGM/C and a future program. The questionnaire was translated into Arabic. The interviewers were asked to translate orally into the local Beja language during the interviews if necessary. They were instructed to fill in the questionnaires if necessary. It was anticipated that a high proportion of the interviewed community members would be illiterate.

The questionnaire was pre-tested. All interviewers participated in a training session prior to the interviews, and follow-up sessions during and after the interview days. (see Annex 2 for the questionnaire).

3.3.6 Validation

Validity was aimed to achieve through triangulation by comparing information and data that were obtained from different sources (data triangulation) or collected through different methods (method triangulation), and by crosschecking the analysed data with the participants (Denzin1978; Carruthers and Chambers 1982). Data and method triangulation was achieved by comparing qualitative and quantitative data. Results of the questionnaire were discussed with different groups of participants.

3.4. Data collection

3.4.1 Primary data

All interviews were conducted with the help of an assistant who also acted as a translator from Arabic or Beja language into English. All interviews used for this study were recorded using a digital voice recorder. Interviews took either place in participants'

homes, offices, or in the meeting room at Tagadom Hospital. The duration of the interviews was not pre-determined. The following primary data were collected:

- 1) In-depth interviews with female and male key informants
- 2) Focus group discussions (both single sex and mixed)
- 3) Questionnaire assisted interviews with closed and open - ended questions
- 4) Mapping of the area
- 5) Observations

3.4.2 Secondary data

The following secondary data that were collected at Tagadom Hospital in the period between October 2006 and May 2007 (Week 42/2006-week 18/2007) were analysed:

- 1) Number of people in the target population
- 2) Number of women with FGM/C amongst women in the delivery unit
- 3) Data on ethnic and geographical origin of women presenting to the delivery unit
- 4) Incidence of FGM/C in the target population
- 5) Specification of excisors (midwife, village midwife, TBA, other)
- 6) Survey of local community leaders and religious leaders from October 2006

Other data that were included were national data from Demographic and Household Survey (DHS) and Multiple Indicator Cluster Survey (MICS) for Sudan.

3.5 Data analysis

3.5.1 Qualitative data

The translated words of the recorded interviews were transcribed. Transcription was done at the so-called "intelligent verbatim" level which aims at a word for word transcription but leaves out any fillers that are not considered relevant to the context.

For the analysis of the interview transcripts, the framework approach was applied. Framework Analysis was originally developed by Ritchie and Spencer (1994, pp.173-

194) for applied policy research where the objectives of the investigation are predefined, and a specific outcome or recommendations are expected. However, as for other forms of qualitative analysis, this form of analysis also leaves room for emergent concepts, therefore is both deductive and inductive.

In this study, after familiarisation, a list of key themes and topics was drawn up from the transcripts. These were based either on the aims and objectives of the study, or on the level of importance as expressed by the participants; or were those topics that were mentioned frequently. Based on these themes, an indexing system was developed and applied to each transcript, using Microsoft Computer software. For example, anything that was related to the practice of FGM/C was coded and copied into the according folder. The coded data were then sorted into categories and, if applicable, into subcategories.

Key themes were then arranged with reference to quotations from respondents. And finally, these entries were then used to “define concepts, map the range and nature of phenomena, create typologies and find associations between themes with a view to providing explanations for the findings” (Pope, et al 2000).

The open-ended questions of the questionnaire were analysed in the same way. In addition, the frequencies of statements relating to certain topics were counted. The topics were then ranked accordingly. The ranking was used as an indicator for importance of the topic and for detection of gender-specific differences.

3.5.2 Quantitative data

The quantitative questionnaire data were analysed using descriptive statistical methods such as percentages. For the analysis of the open-ended questions, the framework method analysis, as described above, was applied.

3.6 Ethical considerations

Approval for the interviews and the administration of the questionnaires were obtained from the Ministry of Health and from the Humanitarian Aid Committee (HAC) in Port Sudan. HAC is the government-designated body to facilitate and support the UN and NGOs' work in Sudan. National Security was informed of any movements involved.

Informed consent was obtained from all participants. This should ideally be in writing but in this study, most of the participants were illiterate. Asking them to sign forms that they would not be able to read could have caused distress. It could have made an impact on the initial flow of conversation, especially during the focus group discussions.

Therefore, verbal consent was obtained from all participants. They were informed that they could refuse participation and withdraw from the interviews at any time. They were also told that any disclosed information would be treated anonymously, and that their names would not appear in any analysis. The same principle was applied to the interview-administered questionnaires. If relevant, additional permission to record the interviews was obtained. The participants were informed that they could ask to stop the recording at any time.

MSF - OCB (Operational Cell Brussels) granted permission for using both qualitative and quantitative data from the project in Port Sudan for this thesis.

3.7 Limitations and constraints

The study had several limitations. It was not possible to interview representatives of all stakeholders involved. For example, schoolteachers, whose opinion may have generated valuable information, were not available for interviews, as this study was conducted during the school holidays. It was not possible to establish contact with any of those midwives or TBAs who were known to perform FGM/C. Men were not as well represented as women.

The questionnaire should have been tested more rigorously before application. For example, the inclusion of the option of "health" in the first question could have contributed to a more reliable result of the questionnaire. However, the importance of health as a reason for FGM/C had not been evident during the design of the questionnaire. During analysis, it also became apparent that one question had been differently interpreted by respondents. Information on numbers and characteristics of both female and male non-respondents were not collected. It is estimated that about 25% of those approached declined to be interviewed. The conclusion is that the current format should be considered as a pilot. The descriptive statistics may indicate a tendency, but the numerical distributions should be interpreted with caution. Errors during this study could also have been arisen from inaccuracies in translation from either Beja language or Arabic into English and vice versa. Most of the researchers and assistants were female. Men may have felt uncomfortable to talk to a woman about such a sensitive issue and may have omitted valuable information.

4 Results

4.1 General characteristics of study participants

Focus groups

The following tables describe the characteristics of the participants of the focus groups and the single interviews. The numbers in the first column refer to the respective number of the recording and transcript. These numbers will also be used in the quotations to trace them back to their original source. 10 focus group interviews and 8 single interviews were included for analysis. The age ranges are based on estimates, as it was not always possible to obtain accurate information regarding participants' ages, especially in the older age groups. The size of groups was sometimes subject to fluctuations, especially in groups 1, 2, 3, and 8. Sometimes people had to leave, or others joined in. Group discussions lasted between 15 and 80 minutes (Annex 3 for details). The transcriptions of the recorded interviews are based on the translations of the research assistant during the interviews.

Table 1: Focus group characteristics

No	Sex	Ethnic origin + description of group if applicable	Age	Location of interview	Size
1	Female	Beja	20-60	Tagadom G	15 women
2	Female	Beja	17-50	Onguab North	20 women
3	Female	Beja	18-70	Onguab South	20 women
4	Female	Beja, Home Visitors	20-35	Tagadom Hospital	17 women
5	Female	Beja , Home Visitors	20-35	Tagadom Hospital	17 women
6	Mixed	Beja, Home Visitors	20-35	Tagadom Hospital	17 women and 2 men
7	Mixed	Beja , Home Visitors	20-35	Tagadom Hospital	17 women and 2 men
8	Male	Beja	20-60	Tagadom Hospital	25-50 men (fluctuating)
14	Mixed	Beja, local NGO (Abu Hadia Society)	35-45	Port Sudan town	2 men, 1 woman
17	Female	Mixed ethnicity, local NGO (LEAP)	20-35	Port Sudan town	4 women

Table 2: Characteristics of participants - single interviews

No	Sex	Position and ethnic origin	Age	Location of interview
9	Female	Community Liaison Manager, Beja	35	Tagadom Hospital
10	Female	Community Liaison Manager, Beja	35	Tagadom Hospital
11	Female	Housewife, Beja	28	Home in shanty area
12	Female	Housewife, Beja	22	Home in shanty area
13	Male	Community Leader, Beja	Estimated ~ 65	Tagadom Hospital
13a	Male	Hospital Logistician, Beja	Estimated ~35	Tagadom Hospital
15	Female	Director of Midwifery School, Beja	Estimated ~45	Midwifery School
16	Male	Director of Social Welfare and Deputy Chairman of Regional FGM network, Beja	Estimated ~55	Department of Social Welfare

Questionnaire**Number of respondents:**

In total, 180 women were interviewed, 11 in each sub area. Additional 15 women were interviewed in the waiting areas of Tagadom Hospital. A total number of 100 men were interviewed in Deim Arab (31), Tagadom (41), and Onguab (29).

Interviewers:

Women were interviewed by 15 female Home visitors and 2 Health Educators

Men were interviewed by one male Home visitor and one Medical Assistant

Table 3: Age distribution of questionnaire respondents

	Women	Men
Mean age	35	46
Range	17-75	23-77
Median age	35	45

4.2 The practice of FGM

4.2.1 Procedure

The operation

The actual procedure of FGM/C is commonly performed as described in the following quotation:

...they use this shaver[razor blade]....they use it to cut her body, and they tie her from here, so as to come the body together from the surgery, just they tie her legs together, and they put sugar, and they cut egg....so as the body to come together. After seven days, they clean the area, and halas. And they are clever in this, they use salty water to clean the area.....It will be pharaonic type, the third type. It is closed, just small place to urinate....No suture, just they cut the place, they cut the place with shaver...And they put a matchstick so as not to close totally. Small opening... (F9)¹

Complications

Reports of complications associated with FGM/C were plenty. Immediate problems were infections and bleeding, sometimes even leading to death. During the study period, a nine months old female infant presented to Tagadom Hospital with massive vulvar

¹ The letters "F" or "M" in brackets after the quotations refer to the sex of the informant (F=female, M=male). The subsequent number refers to the according interview/transcription. The letter "Q" refers to the questionnaire, and the number that follows, to the respective question.

oedema and urinary retention following circumcision three days earlier. Long-term problems that people related to FGM/C were problems arising from scars, problems with urination, cysts, period problems, infertility, and general pains. Women also talked about pain and loss of pleasure during sexual intercourse.

I met one woman last week, and she circumcised her girl...her age is one year, and she said that they referred her to the hospital because after they circumcised her she had some infection. (F1)

I have good experience about the danger of this practice. When they did it to my daughter, she started bleeding, and she died before we could transfer her to the hospital. From that time until to-day, I feel like a killed my daughter, and I did not do it for my remaining daughters. I advice all the people to stop this harmful practice. (M13)

Forgive me about what I did for my daughters, I ask now the people not to do this because until now I am suffering, until now I have pain in my body...(Older woman F1)

Yes, in the relationship with your husband also this will make some problems... (Older woman, F2)

W1¹:...and same pain, I think, again when in marriage...the same pain

W2: another problem...

W1: This pain!

W3: They say this pain come for us like a mountain!

W1: Pain, pain, pain, woman pain!

W3: circumcise, marry....

W1: I was married one day, and I now got divorce because my husband wanted me to be re-sutured, to be re-circumcised again.

He said, go...And I take my child and go to my parents. (17)

Celebration and presents

¹ "W1", "W2", and "W3" stand for three different women.

The day of the circumcision is usually celebrated. The girl's hands and feet are painted with henna, and she will receive presents or money. In the past, big parties were common, many people were invited, and FGM/C was performed publicly. Now, the operations are increasingly done in secrecy, or even under pretense.

...they did a party for her and they put the henna and they did big ceremony for this, and they said, we want to circumcise our girl, they invited all the neighbours and all the family and they all came, and they did a party, it used to be like a wedding day before... However, to-day, this has disappeared, and if the woman wants to circumcise their girl, they just circumcise, not like the last times. Without celebration, without any announcement, without anything, they circumcise them... (F1)

Even I remember when they decide to do it for us, they said: "You will get a lot of money and we will give you, and you can buy something...(F17)

Audience

You asked if everybody is watching while it is done? No, no....the midwife, and the mother, grandmother or grandfather. In the past they were making it in front of their people. A lot of people. But now they are doing it in closed place. (F17)

Pretence

W1: Some families they do like that, pretend.

W2: They tell everybody that they make for this girl the circumcision, but they not make it. They just put the Henna and celebrate... (1)

Defibulation and Re-infibulation

During childbirth, women have to be cut open or "defibulated" to allow the passage of the fetal head. Re-infibulation after deliveries is a common practice, and the aim is to recreate the state of virginity. This is often complemented by a complete new outfit including hair, make-up, and clothes so that women can represent themselves as a "new woman" to their husbands. Some women will undergo regular re-circumcision irrespective of childbirth.

4.2.2 Age

FGM/C is usually performed on girls between the age of 7 days and 5 years. Some say that younger children would feel less and show less resistance, and it would be easier to handle them. Many of those circumcised at an older age remembered the day and could recall details such as the colour of their clothes and the presents. One woman described how she tried to run away, but the whole village ran after her to catch her. Male circumcision is performed between 7 days and 7 years.

...we found different age in our area. From seven days up to four/five years. (F9)

R¹: Are the boys getting circumcised? F: As babies, from seven days. Yes, until seven years old. But for the girls it is better for them to do before five years. They say that if she is five years or something like that she will understand what it is and she will cry a lot and she will feel...it is better to do it for her when she's child. (12)

4.2.3 Estimates of prevalence

Table 4: FGM/C in the delivery ward between October 2006 and April 2007

	2006 (week 40-52)	2007 (week 1-17)	Week 40/2006 - week 17/2007
Total no of deliveries	145	356	501
FGM/C total numbers (percentage of total no of deliveries)	88 (61%)	160 (45%)	248 (49.5%)
Non-FGM/C total numbers (percentage of total no of deliveries)	57(39%)	196(55%)	253(50.5%)
FGM/C I+II total numbers(percentage of total no of FGM/C/C)	16 (18%)	23 (14%)	39 (16%)
FGM/C III (percentage of total no of FGM/C)	72 (82%)	137 (86%)	209 (84%)

¹ "R" refers to the interviewer.

Data collected on the delivery ward at Tagadom Hospital between the period of week 40 in 2006 and week 17 in 2007, showed that 49.5% of 501 women showed signs of FGM. Of those, 84% were infibulated (type III), the others showed either type I or II FGM.

Data documenting ethnicity showed that Beja women represented about 30% of all women attending for deliveries during this period. 19% of women were Beja from the study area. 70 % of women were from other groups such as the Hausa, Fellata, or IDPs from the West and the South. As ethnicity was not linked to individual women and FGM/C status, it is not possible to draw any conclusions with regard to prevalence amongst a particular ethnic group.

However, based on observation by staff in the delivery unit, it seems that the majority of Beja women are infibulated. Beja community members have estimated that prevalence of FGM/C may be as high as 90-100%.

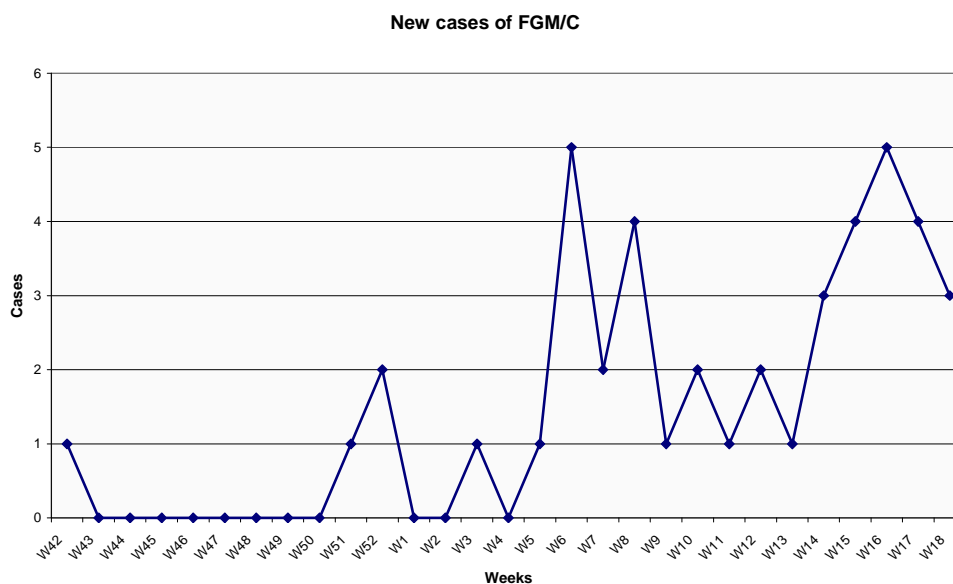
4.2.4 Incidence

The Home Visitors started to collect data on new cases of FGM/C in Tagadom, Onguab and Deim Arab in week 42 in 2006. Type I and II were grouped together as it is often not possible to distinguish clearly between these two forms. Number of newborns during this time was 339. Age at time of circumcision was not documented.

Table 5: Incidence FGM/C (15/10/06-5/5/07)

	2006 (week 42-52)	2007 (week 1-18)
New circumcisions	5	39
FGM Type III	2	27 (69%)
FGM Type I and II	3	12 (31%)

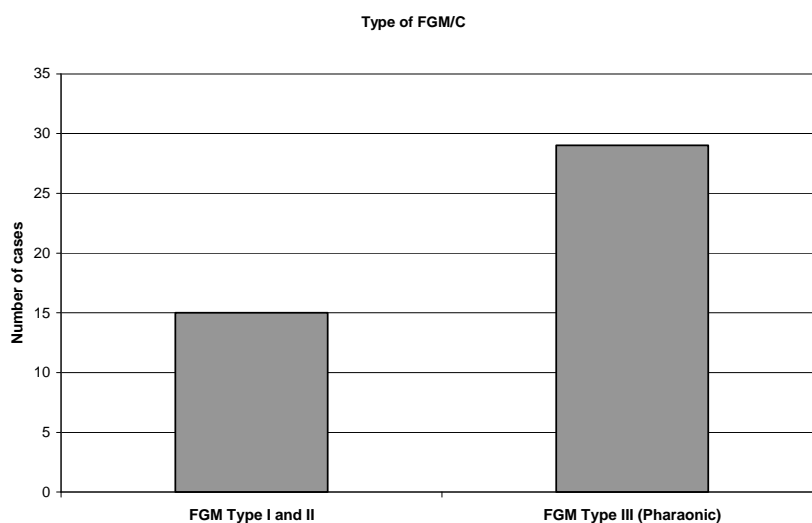
Figure 3: Incidence FGM/C (15/10/06-5/5/07)



New cases of FGM/C increased towards the beginning of 2007 with peaks in February and April.

...and really, last 3 months, there are a lot of cases of FGM. And it was Pharaonic type, 6 of the 3rd class of FGM. And it was done by, really it is a illegal midwife, traditional midwife, it is not legal midwife. And this is our information. (F9 on 22.3.2007)

Figure 4: Type of FGM/C in new cases (15.10.06- 5.5.07)



4.2.5 Decision structures

During the interviews, women said that mostly mothers and grandmothers take the decision regarding circumcision of their girls. However, once the decision is made, they will inform the husband who either accepts or refuses their decision. Sometimes, discussion may take place, and whoever has good arguments, will be able to convince the others. They said that sometimes their men have more knowledge or ideas, and can therefore convince them not to circumcise.

...it is a woman's decision but before to take the decision, they have to discuss with their husbands...and if the husband comes and sees that his daughter is already circumcised he will not refuse, but if you discuss with him about this, maybe he will refuse and give her some reasons of not to circumcise the girl. (F1)

...yes, and it is true, sometimes the men know more about this issue.... because it is the decision of the grandmother and mother sometimes the men cannot say anything about this... but for four of my daughters they refused, their husbands refused to do the circumcision for their girls (Older F1).

In the end, the strongest person will decide:

Yes, the grandmother, and even if the father is strong, sometimes the grandmother is stronger than he is, and for that, she decides and she takes the decision. (F2)

You see, here in our community, the women are stronger than the man in the house, and if they want to take a decision without telling him, they can easily do so. When we held a big meeting with the men, they said: "FGM is not our business. The women come to us, especially the grandmothers, and say: We want to circumcise this girl, just give us money for this midwife. And we pay, without any veto..."(F2)

Women also said that usually they do not discuss FGM/C in general or any other "women's issues" with their men at home, and certainly not in public.

Even in home, sometimes we feel shame to discuss with him about women issue. (F1)

Because it is really shameful to discuss about this issue, and it is really not good for our girls to discuss about this. (F10)

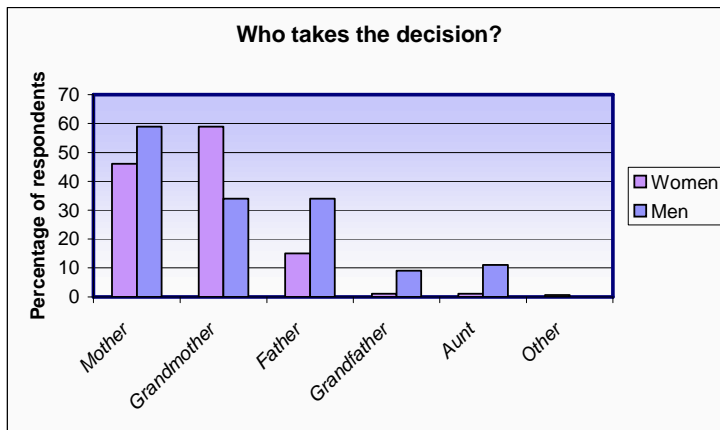
No, for the men no, until now they do not discuss, but for the women, yes they discuss with each other, they discuss. (F2)

In their questionnaire responses, men rated their importance in the decision-making process higher than the women did. However, it is also possible that they referred to their role as sole decision makers with regard to boys' circumcisions.

Table 6: The decision makers (questionnaire results)

	Mother	Grandmother	Father	Grandfather	Aunt	Other
Women	46%	59%	15%	1%	1%	<1%
Men	59%	34%	34%	9%	11%	0%

Graph 3: The decision makers (questionnaire results)



4.2.6 Performers

The main performers of FGM/C are midwives and traditional birth attendants (TBAs). In Sudan, different levels of midwives exist, according to education and training.

Community or so-called village midwives, are those who have received the most basic

medical training, which usually lasts 1½ years. During their graduation, they swear and sign on their certificates not to perform FGM/C.

The midwives even swear about this. They swear not do to FGM...(F17)

TBAs are illegal in the country. They have received training in the past, and many are still active in the community but they are not recognised by the Ministry of Health. For both midwives and TBAs, FGM/C is an invaluable source of income.

During the interviews, women frequently mentioned one particular village midwife who was known to practice FGM/C.

Home Visitors' data collected between week 42 in 2006 and week 18 in 2007, documented the following performers for new cases of FGM:

Table 7: Performers of FGM/C as documented by the Home Visitors

Village Midwives	TBAs and others
64%	36%

In the questionnaire, more women referred to the village midwives as the main performers, whilst most men named the TBAs. In addition, men also referred to "other" more frequently.

Table 8: Performers of FGM/C (questionnaire results)

	Village Midwives	TBAs	Other
Women	54%	43%	5%
Men	35%	68%	20%

Clarification regarding "others" during interviews suggested either family members, or health professionals as performers. It was also proposed, that men could have misunderstood the question and referred to male circumcision, which is mostly performed by health professionals.

.... some women they do it for their daughters, even if you ask them not to do this, the women are now trained to do it like TBAs...(F6)

...because now I can understand, the men can take the decision for their boys, and they can go to medical assistants and doctors sometimes... (F6, Research assistant)

4.3 Reasons and beliefs for the practice of FGM/C

4.3.1 Overview

Exploration of the second objective was carried out through analysis of all interviews, and questions one and three of the questionnaire. Question one of the questionnaire asked for the reasons of FGM/C in the community. Respondents could choose several of the five following options: Tradition, Religion, Husband's preference, Hygiene, Other.

The third question was open-ended and asked for people's thoughts regarding women's benefits of FGM/C. Most respondents made short statements. The content of the statements as well as the frequency count of particular themes were included in the analysis. These frequencies served as a basis for a gross comparison between women and men's responses.

Most of the results of this part can be described under the following major categories:

- Cultural heritage
- Health and hygiene
- Psycho-sexual reasons
- Religious reasons
- Other

4.3.2 Cultural heritage

Tradition and custom

In this category, "Tradition and Custom" were often used either together, or synonymously. "Habit" was another expression commonly used.

It is our habit and it is tradition, yes our tradition as the Beja...(F11)

This is from the community, myth, idea, from the community (F12)

...this is habit from our grand grand grandmothers, and that means we inherit from our grandmothers, and we have strong belief about it. (F3)

...for many many centuries people did this practice, why now these people come and ask us to let this habit? Now it has become like habit,... people believe it and it has become like their daily needs and their life needs, it is difficult to leave this habit, or to leave this practice....(F10)

...there is no clear reason for that but we can say it is inherited habit, from the ancestors and old people in our community. They find their mothers and fathers do it and they did for their daughters. (F15)

Questionnaire responses showed that more men than women opted for "tradition":

Table 9: The reasons for FGM/C (questionnaire results)

	Tradition	Religion	Husband's preference	Hygiene	Other
Women	66%	7.2%	13.3%	26.1%	3.8%
Men	85%	14%	4%	12%	0%

In their responses to the open-ended question 26% of women and 33% of men referred to habit, tradition, and/or customs. Expressions like the following were common:

Just a habit (FQ3)

It is from our traditions and customs (FQ3)

It is ancient habit (MQ3)

Very ancient habit from Egypt by pharaoh (MQ3)

It is customs and traditions inherited by pharaoh to our grandfathers and mothers (MQ3)

Because all do it (FQ3)

A few women thought that FGM/C was practiced everywhere and were surprised to hear that women were not circumcised in other parts of the world.

Stigma and shame

Non-compliance with tradition and custom may result in stigmatisation and shame.

It may be difficult to stand up alone against the majority:

...this is myth, idea from the community; if some houses together decided not to do it, it can be easy for them; but if one says that I will not do it, although all the community does it and wants to do it, this is difficult. (F12)

Children will be stigmatised at school if they are not circumcised.

...when she went to the school her friends asked her: “Did they do for you this circumcison?” And when she said to them: “No, they didn’t”, they said “Uuuuuh, why they did not do for you, it is shameful, and it is not good, ...” (F9)

If my daughter goes to school and she is not circumcised, her friends will ask her: “They did for you?” And if she said then: “No”, they will look at her. (F1)

In response to the questionnaire results, about 7% of men and 2 % of women mentioned stigmatisation or shame:

Because it is shameful not to do (FQ3)

Considered a scandal if not done (FQ3)

Beja stigmatise uncircumcised girls (MQ3)

...and if they didn’t do it, then people feel shame. For that it is...it will take a long time to fight it... (M8)

4.3.3 Health and Hygiene

Health

Both women and men consider FGM/C as an important factor for health. Health issues were frequently raised during the interviews. Health had not been included as an option in the closed question of the questionnaire. However, statements in response to the open question revealed that about 26% of women and 20% of men considered FGM/C as

beneficial for women's health. FGM/C is assumed to keep healthy and prevent from various forms of illnesses. This was often expressed in an unspecific way.

It is healthy practice (FQ3)

To keep the woman healthy from infection (FQ3)

It strengthens woman's health (MQ3)

It is good for health (MQ3)

Because uncircumcised female usually can be infected with incurable diseases (MQ3)

Keeps safe from dangerous illnesses (MQ3)

Or it was related to certain circumstances:

To keep the woman healthy especially when they are pregnant (FQ3)

To keep women healthy, especially after the delivery (FQ3)

Helps for giving birth (MQ3)

Some women also thought that during childbirth, the baby might just fall out if they are not infibulated. During one interview, one woman told the others of how she once witnessed an uncircumcised Nigerian woman giving birth. Apparently, this woman just went to the toilet and delivered by herself. This story was met with a mixture of disbelief and surprise, and women could not imagine how to deliver without assistance. They also thought that "being open" and not infibulated could lead to uterine prolapse. It would also make them more prone to infection.

Some men were quite explicit in their description of local effects on the genital tract:

Clitoris is ill useless part (MQ3)

The clitoris is bad part in women's organs (MQ3)

It [the clitoris] will be infected with some worms (MQ3)

To prevent female from vaginal disease (MQ3)

Cleaning for women organs (MQ3)

Because the clitoris causes incurable diseases (MQ3)

It is healthy for us to remove this sensitive area because otherwise some blood will go in all the body ...And this place [the clitoris] is not useful. If they did not circumcise me, I would not be like this now. I am healthy now...(F3)

Some people believed in systemic effects:

It is useful, for the safety of the liver (MQ3)

FGM/C is considered especially beneficial for children when they are generally ill or not thriving:

...and they have belief like this, they say that if they don't circumcise their girl, she will be sick for long time and she will not be well...(F3)

...this is where the infection came from, if they did not remove this place [the clitoris], when we removed this place now she started to get well, and we have a lot of examples in our area...(F3)

If they don't circumcise her she will be sick for a long time or this will lead for anaemia or something like this, and for that they circumcise their girls (F1)

...if our girl does not grow up well, if she is sick for long time, and then we go to doctors, and they give us some treatment and it is not working well, and then we go to traditional healer, and then we circumcise her, and because we think and believe about this, she will grow well and she will be well, it is healthy for our women, for our girls...(F3)

Apparently, FGM/C is often considered as a treatment for eye and skin diseases in children (F14). A particular assumed benefit both believed by women and men is the protection against some animals and their venoms:

.... and especially protect from scorpion bites (MQ3)

If any insect bite the woman, FGM will protect her from the poison (MQ3)

Prevents from insects (MQ3)

When insect bite uncircumcised girls immediately she will pass away (MQ3)

...for a boy also, if they don't circumcise him, or if something bite him, a scorpion or a snake, he will die, if he is not circumcised, the girl and the boy, they say this will protect them...(F3)

Specifically regarding re-infibulation women said that they were afraid of infections.

...they think that if they open after they have been closed for many, many years, it will lead for infection or it will lead for many diseases. And this is their reason. (F9)

Hygiene

During the group and single interviews, hygiene and cleanliness were not mentioned. However, amongst the questionnaire options, it was chosen by 26.1% Of women and 12% of men as depicted in Table 9. In the open-ended statements, only about 2% of women mentioned hygiene as a benefit of FGM/C. 4% of men referred to "purification".

For cleaning (FQ3)

Useful for the hygiene (FQ3)

4.3.4 Psycho-sexual reasons

Husband's preference

During the interviews, women frequently stated that they think that men prefer them circumcised:

...men, they do not prefer uncircumcised. After delivery, women are re-sutured. (F17)

Because the men want the girls to make FGM. They like it! That's why you cannot destroy it. They prefer woman with FGM, they prefer this woman. They don't like woman not circumcised. (F17)

The menthey don't like the women who are open (F11)

In the questionnaire, more women (13.3%) than men (4%) chose the option "Husband's preference" as reason for FGM/C. In responses to the open-ended question, 12 % of women made statements referring to men's preferences in a sexual context. Only one man made a comment regarding his sexual preference.

To keep the husband (FQ3)
For the desire of the men (FQ3)
Husband enjoys the sexual life like this, more satisfied (FQ3)
According to the husband's desire (FQ3)
It helps the women to keep their husbands (FQ3)
It will create good relationship with the husband (FQ3)
The men prefer it (FQ3)
Men prefer circumcised females (MQ3)

The most common expression in this context was:

According to the willingness of the husband (FQ3)

Control of women's sexuality

During the interviews, men did not talk about sexuality. However, in response to the questionnaire, 18% of men's statements related to women's sexuality as compared to about 4% of women's responses.

FGM/C is believed to reduce the libido:

Reduces sex appetite (MQ3)
Reduces the desire for sex (MQ3)
Makes sex appetite weak (MQ3)
Long riding distance by camels increase the desire to practise sex (MQ3)

.Really, they said if the girl had high education and she very happy girl ... it is better for her to circumcise her, because if she's grown and a woman she will be ... (laughs) (F12)

Other statements referred to sex before or outside marriage:

Reduces sex appetite and threat to her marriage (MQ3)
Saves from hidden sex (MQ3)
Stops girl from illegal sex exercises (MQ3)
To keep the ladies not to do shameful things (FQ3)
Protection against girls doing something bad (FQ3)

Some women, on the other hand, thought that FGM/C did not give a guarantee for faithfulness:

...she can do as she wants and then can infibulate again... (F3)

Virginity

Women rarely talked about their own sexuality but mentioned "virginity" more often. About 22% of women considered virginity a benefit of FGM/C, as compared to about 5% of men.

Because it keeps a girl's virginity (MQ3)

To maintain virginity (FQ3)

Keep virginity and as matter of pride (FQ3)

...they believe that if they circumcise their girl she will maintain virginity and that's why they circumcise her, to keep her safe... (F1)

Marriageability

1% of women's and 3% of men's responses referred to improved marriage aspects.

It is shameful not to circumcise, and we will not find husband for her (FQ3)

For the future of the girls (FQ3)

Increases the chances of marriage (MQ3)

Regarding reinfibulation

Women were convinced that men would not agree to defibulations.

And because they removed all the sensitive part of the body, it has no meaning for opening now. And the other things is that our men will not agree with this. They will not agree to see us open like this after many many years. It is not good for us.

Some men, on the other hand, said that the safety of their wives and newborns was more important.

If they do it for them now, after they cut all the sensitive parts, it will be like transportation way. It is open but nothing inside! ...But if it is good for her after delivery, no problem with us. It means nothing for us. (M8)

...it was not very important for them to reinfibulate or not to reinfibulate just if they find their women in safe situation or their babies in safe situations it not a problem for them to reinfibulate or not. (F10, recalling a conversation with men)

4.3.5 Religion

During the interviews, religion was mostly mentioned briefly when participants listed the reasons for FGM/C. One woman referred to the controversy that exists regarding the interpretation of the Prophet Mohammed's reference to FGM/C:

...it [infibulation] is not as I read in the Koran books and in religious books. Also, it is not, what our prophet said. People say it is according to faith but it is not. Really, our Prophet did not do this practice for his daughters.....and he did not ask his friends to do it. Just when this woman came and asked him: "What can I do?" He said to her: "Just cut, not to cut all, just to take the head of the clitoris". (F4)

In the questionnaire, men named religion as reason for FGM/C second frequently, while for women it ranked on place four (14% vs. 7.2%) In response to the open-ended question, about 12% of men made a statement about religion, and 2% of women. The statements were usually short:

It is from our Sunna (FQ3)

It is Sunna, approved by Prophet Mohammed (MQ3)

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4.3.6 Other

Aesthetic reasons

In response to the open question of the questionnaire, 3% of women considered FGM beneficial for their beauty. Men did not mention aesthetic reasons.

For the beauty of the girl (FQ3)

Protection

The following statements refer to beliefs that are based on the existence of spirits and the evil eye.

To protect our girls from the devil (FQ3)

To keep away the danger of other human beings and the devil (FQ3)

There is the belief that uncircumcised female will be infected by fatal diseases and evil. (M7)

Economical reasons

Not only does the practice of FGM/C provide an income for the performers but sometimes for the families:

Even for the family, some sort of income...not only for the midwife...If some family needs money, they circumcise their children to get money from relatives and friends, fill their house...The poorest families, they do not resist, as it is income for them...Why, why this is very strong among the poorest families? When you make for the girl the circumcision, the other people bring for the girls. (F17)

4.4 Attitude

4.4.1 Attitude towards FGM/C

Attitude was explored through community members' readiness and willingness to discuss the topic of FGM/C, through their comments during the interviews, and through question 4 to 6 of the questionnaire. Participants were asked about their opinion regarding the continuation of FGM/C, and to give reasons for their preferred option. In addition, they were asked whether they would circumcise their daughters in the future. Other data looked at was a survey of local community and religious leaders from October 2006.

Readiness to discuss FGM/C

Observations during the interviews, including the interview-administered questionnaire showed that many men felt extremely uncomfortable speaking about FGM/C. During the focus group session with men, about a third of all men suddenly left the room after realizing the topic of conversation. However, many of those had come uninvited expecting a discussion regarding the future of the hospital. They did not want to talk

about FGM/C because "it is a women's issue" and men do not consider it "their business". During the questionnaire-administered interviews, some men apparently reacted rather aggressively, and about an estimated quarter of both women and men did not want to talk and give their opinion about FGM/C.

Because it is really shameful to discuss about this issue, and it is really not good for our girls to discuss about this. (F10)

On the other hand, the impression during the interviews with women was that most of them welcomed and liked the discussions about FGM/C, especially in groups. It seems that this was a recent development.

She said it is very nice issue, now we can speak, now you come and make this, we can take our freedom to speak, because before the women feel shame to speak about this. (F1)

This is your time, my daughter...we did not speak about this issue, we did not discuss together, never spoke about this issue before, but now the women they can speak together and they can discuss together this issue, and she said: "this is a new time for the women"...(older F12)

Women confirmed that they usually do not discuss FGM/C or any other "women's issues" with the men:

No, for the men no, until now they do not discuss, but for the women, yes they discuss with each other, they discuss. (F2)

Even in home, sometimes we feel shame to discuss with him about women issue. (F1)

Opinions regarding the future of FGM/C

Question 4 asked if people thought that FGM/C should be continued. Results are described in the following table.

Table 10: Continuation of FGM/C (questionnaire results)

	Yes	No
Women	52%	48%
Men	46%	54%

Open-ended question 5 asked participants to give reasons for their answer in question 4. The reasons given to support continuation were similar to the answers given previously in response to question three. Regarding the responses of men, both lists of themes showed a similar distribution. The only exceptions were that fewer men stated control of women's sexuality (4% vs.18%), and some (~4%) admitted their preference of circumcised women:

Because women without clitoris are more loved (MQ5)

Men like circumcised girls (MQ5)

Analysis of women's statements suggested that 20 -30% might have understood the question as follows: "Do you think that FGM/C will continue?" Therefore, some did not give their personal opinion but rather prognostic statements. In addition to these prognostic statements, they named the same themes, as previously. The most frequently stated reason was "tradition" (61%), all other reasons were mentioned less than 5%. However, because of the inconsistency of their answers due to different understanding of the question, the numerical distribution of themes was not compared to their responses to question 3.

Attitude towards reinfibulation and non-reinfibulation

It seemed more difficult to approach the subject of reinfibulation than FGM/C in general, or in children. The impression from the interviews was that many women did not agree with the new policy of non-reinfibulation after deliveries at Tagadom Hospital.

We are very happy that some of our problems are solved nearby but we do not 100% agree about this non-reinfibulation, but what shall we do with this? What agree? And because it is not from our culture, and it is a new thing for us, we have to think about this first...(F3)

Change of attitude

During the interviews it was frequently mentioned how the attitude and practice had already started to change.

In my family my daughter they refused to do for their girls... (F1)

The women who delivered last year, like this one and this one, they agreed not to be re-infibulated, they agreed, and now they are open. (F1)

My daughter is suffering from this practice and for that I will not agree to do it for their daughters. (F1)

If we did have girls we did not circumcise them because now we know how they will suffer. (F1)

For the old ones, already they did it, but for the one who will deliver or the new ones, we will not do it. We think that we will not do it. Yes, everything has changed, why not this one. We have to change it. (older F12)

Some women also reported how they had or would change to less invasive forms of circumcision, such as "sunna".

A change of attitude was also reflected in the questionnaire statements of those who voted for discontinuation of FGM/C. Approximate percentages of the frequency of statements are noted for women and men, to give a rough impression of the order of importance. Again, about 30% of women made prognostic statements or gave an evaluation of the current situation instead of their personal opinion. Men on the other hand, mostly expressed their own opinion. Therefore, the percentages below should not be used for a comparison between women and men's answers.

Some respondents made general statements (Men 15%, Women 19%) referring to FGM/C as "bad acitivity" and "dangerous", or they thought that it was useless or

harmful and had no value and benefit. A couple of men used some more drastic expressions:

Because it is sadism (MQ5)

It is genital mutilation (MQ5)

Most commonly cited reasons for discontinuation were health consequences (Men 60%, Women 20%):

Causes illness (MQ5)

Dangerous complications when giving birth and after (MQ5)

Not good for health or delivery, also psychologically bad impact for child (MQ5)

Physical complications (MQ5)

Because painful for the girls and boys when they want to exercise sex (MQ5)

Circumcision makes infection and oedema (MQ5)

Can end life of innocent persons (MQ5)

Girls will die if not stopped (FQ5)

Both women and men referred to the impact on women's sexuality:

Not good for health, and women loose pleasure of sex (MQ5)

Because cutting the clitoris make female insensitive for sex (MQ5)

Without FGM/C there is extra part on women's sexual system (FQ5)

Tradition was also cited as reason by about 10% of both women and men; however more in terms of habit that was not worth of continuation.

Just old habit (MQ5, FQ5)

Religion was mentioned by 5% of both women and men:

Because not mentioned in the Islamic religion (MQ5)

Not from our religion (MQ5)

This is about the creation of the people, and it is Allah who created the woman like this, and why should people change. Also, did God want to remove all the sensitive tissue around this? (F5)

4% of men stated the assumed foreign origin of FGM/C as reason for discontinuation:

Inherited by Pharaohs (MQ5)

The remaining few statements focused on the law, and the economical gain of the midwives

Because it is forbidden (FQ5)

Because only midwife benefits from this by taking money (MQ5)

One man stated his preference of uncircumcised girls.

Uncircumcised girls are sweet (MQ5)

Those women, who made statements that were prognostic, said that FGM/C would not continue because awareness raising had already started. FGM/C **will not continue** because....

Awareness raising has started (FQ5)

Because the message of fighting FGM/C has spread through media and magazines (FQ5)

Because it has spread over Sudan (FQ5)

People have started to think (FQ5)

People have started to fight it (FQ5)

Some of us do not care about this practice (FQ5)

A lot of efforts were done (FQ5)

Because people understand that it is harmful practice (FQ5)

Women are encouraged by others who have stopped (FQ5)

Future behaviour

Question 6 asked if the participants would have their daughters circumcised in the future. The results were similar as in the question 4:

Table 11: FGM/C of daughter in the future

	Yes	No
Women	52%	48%
Men	45%	55%

Attitudes of local leaders

Community Leaders:

A survey previously done by MSF included ten community leaders. Of those, four were from Onguab and three from Tagadom. Three community leaders were not from a specific area but respected as leaders by the community because of their age or education. Eight of these men were entirely against FGM/C. Two of them were against Type III circumcision but supported "Sunna" (FGM/C Type I). Total number of community leaders is not available.

Local religious leaders:

Survey of ten local Imans of Deim Arab (3), Tagadom (1) and Onguab (4) showed that they were all against Pharaonic circumcision but supported the practice of "Sunna".

Total number of Imans is not known.

Four of five female Koran teachers stated that they would not support FGM/C. One teacher supported the practice of "Sunna". Total number of female Koran teachers is not known.

4.4.2 Attitude towards a programme on FGM/C

The impression was that the majority of people were in favour of a programme. This was reflected in the statements to question nine, asking for ideas for a programme. The answers were mostly very constructive and enthusiastic and will be presented in paragraph 4.4.3. Some also advised to focus on FGM/C in general, and not only on pregnant women and the issue of non-reinfibulation after deliveries.

...but if you focus on the ones who deliver or if you focus just on ANC...this is not useful for our future girls...and even if the women are not infibulated after deliveries, they will go and forget about their girls...(F9)

All ten community leaders who had taken part in the survey discussed previously, said that they would be willing to participate in a programme, and to advise people on FGM/C. During interviews, community leaders confirmed their support as well.

In regard to FGM issue, although this it is an old habit, we are ready to cooperate with you, and inshallah, we will try to use lectures, and through lectures it can be reduced. We are ready to cooperate with you. (M8)

An old and much respected community leader said:

FGM is the most important issue for our community, and I think the Home Visitors now speak about this issue in our community, and we want them to continue like this. (M13)

Local religious leaders all said that they would be prepared to advise people not to perform FGM/C type III, and they would participate in a programme. They were also asked to estimate the average size of their audiences. They estimated that between 150 and 300 people would attend daily, and between 300 and 500 people during Friday prayers. The female Koran teachers who took part in the survey said that they would be willing advise the attendees at their school against FGM/C.

Representatives of local NGOs confirmed their acceptance and support of a program.

We will be proud if you join our network! The program will take some of our workload...(M16)

I think we will not debate about the collaboration and coordination, and we will support you, this is our goal, to support anybody who works against FGM...(M14)

4.4.3 Ideas regarding an FGM program

The ideas regarding a programme as suggested by Beja community members derived from both the interviews and the questionnaire. A common answer and term used by the translators or people who spoke English was "awareness raising". The themes mentioned in response to question nine of the questionnaire can be grouped together as follows:

- Awareness raising with regard to health/medical issues (women 23%, men 23%)
- Awareness raising with regard to religious issues (women 20%, men 13%)
- Interventions through law and lobby (women 9% and men 15%) and other

The remaining responses focused on the methods and tools, the target groups, and the trainers. A few suggestions did not fit into any of these categories, and some people thought it important to focus on other needs as well. 27% of men and 13% of women made negative remarks regarding a programme.

Some respondents made comment regarding the time it would take to change the community's attitude towards FGM/C:

If you want to do something, it will come slowly, slowly. Step-by-step it will stop. (F15)

Awareness raising with regard to health

Show the people the dangers of FGM (FQ9)

Show the community how the woman is suffering during delivery (FQ9)

Teach families that FGM affect women health by diseases (FQ9)

Health education with video show and pictures about FGM (FQ9)

We have to do awareness raising for the people to show that this FGM/C is a very harmful practice, is a very painful practice and it will lead to a lot of problems (F5)

One man recommended, "To keep the newborns safe" (MQ9).

Awareness raising with regard to religion

The suggestions with regard to religion were not very specific except for the choice of speaker (see under "trainers").

To explore for the local community that it is not recommended in religion (FQ9)

Religious lectures (MQ9)

Interventions through law and lobby

Many advocated a focus on the midwives but more in terms of activation and enforcement of the law.

Sentencing the midwives (MQ9)

Very committed governmental law (MQ9)

Stand strongly against the midwives (MQ9)

Punish midwives (MQ9)

To warn midwives, they have to swear not to do FGM/C (MQ9)

Ask the midwives not to do it and activate the law against them (FQ9)

Fight the one who does it (FQ9)

However, some showed more understanding towards the midwives. If they stopped performing, they would lose out on income.

The lecture is not enough to stop this...if you ask them not to do circumcision, what is another choice for them? I think it should be parallel...and some of them they believe it is not good, but they need their business, lack of salary ...(F17)

Other proposed approaches included public messages by the government and NGOs:

I think if the Sudanese government asked them not to do FGM for their girls, and all the NGOs that work on this would join, and any other clever people, and if there was a law about this bad habit - then they wouldn't do it for their children... (M8)

Another idea was to include a message against FGM/C in the birth certificate:

...we have to do more work for the policy change, to meet the minister of Health, to put message in each certificate, to do message against FGM...(M14)

Methods and tools

Many of the suggestions of both women and men referred to sessions, workshops, or lectures.

Women said that they would meet in their homes, at women's meeting places, and schools. Men suggested "awareness raising at school, club, mosques" (MQ9).

There is a traditional gathering...a women's gathering for drinking coffee together, this could be good to change their attitude towards FGM, they organise themselves, they meet weekly, every week they meet at one of their friends' house...(F17)

People suggested use of "visual and audio mass media" (FQ9). Women said that they like to listen to the radio, and some have access to TV run by car batteries or generators (F1). Some women remembered a TV programme from Egypt about FGM/C that had been broadcasted 3-4 months previously. It had shown pictures of infibulation, and they said that everybody talked about it afterwards (F1).

The following tools were suggested:

Distribution of posters, leaflets (MQ9)
Replacing billboards in public areas (MQ9)
Video shows (MQ9)
Mass media (MQ9)
Local radio (MQ9)
Cassette tapes in local transportation (MQ9)
Mobile theatre, drama, role-play (MQ9)

The director of the midwifery school said that she did not have any training material for FGM/C (F15).

Some men suggested taking advantage of public events:

Speak out in celebrations (MQ9)
Collective discussions in the public areas (MQ9)
Take advantage of celebration to collect people together and conduct sessions (MQ9)

Some women would like education on FGM/C combined with free health services:

Free health days, free clinic (FQ9)
Health days for the community: mobile clinics (FQ9)

Target Groups

Most comments from the questionnaire regarding the target groups suggested to include women and men from different groups, and to focus on several generations:

To convince the leaders, women, midwives, students, and especially grandmothers that it is forbidden and harmful (FQ9)
Health education for parents and grandmothers (MQ9)
From the children to adults (FQ9)

We make session for women and men together. (F17)

Some women suggested focusing "especially on the men" (FQ9):

Yes, we can speak with the women, and step by step we will try to convince them but the most difficult thing for us are the men...(F5)

Both women and men proposed to target young people, and to focus on teachers and schools:

Train young girls on the bad impact of FGM/C (MQ9)

Health education in schools (MQ9)

Awareness raising especially for the students (FQ9)

Also, the school we have to put into our mind, also. School programme. If we want to speak about this we have to go to the school and we have to speak about this in the schools. (F9)

Some suggested focusing on "illiterate individuals" (MQ9). Others thought that it was important not only to focus on the town of Port Sudan but also to include people in the rural areas.

Trainers

Respondents made plenty of suggestions with regard to who would be most suitable to advance the program.

All the leaders have to speak about this issue, especially the religious men (FQ9)
...traditional leaders, tribal leaders, community leaders, local committee members...
(MQ9)

...just awareness raising and use the leaders and use the religious men, the key persons, to find the key persons ... and finish. The community leaders, the schoolteachers, and the religious men and the religious women also can speak about this. (F9)

People said that they would prefer to get information from educated Beja people.

...sessions by educated Beja male and female because they trust them more (MQ9)

They would not accept information or education from other tribes but make an exception for "white people":

Beja people if you go to them you can easily convince them...if I say to them, chawaja said - chawaja is a white person - they can believe, I can easily convince them. But for another Sudanese tribe they are suspicious...And if some people came from another tribe and tried to convince them they would not believe them. (F9)

However, the importance of speaking Beja language was stressed:

Lectures in local language (FQ9)

...we need educated people and they know what they are speaking about, and who also speak to them in their language, by their concept..., it is a little bit difficult but it is not totally difficult! Possible under the sun! And we will try and will do our best and...one day I am sure...(F11)

No one really spoke about this issue before. But most of them, and maybe some of the Home Visitors also, they cannot understand classic Arabic. Really, they speak Beja Arabic but this classic Arabic is difficult for them. 90% of them they cannot understand Arabic language in the area. (F4)

Another idea was the training of trainers. It was suggested that, e.g. the Home Visitors could be trained and supervised by medical and religious experts.

...so first to teach them, second to go with them to the area, third to go by themselves to speak with the community (F5)

Some people proposed to include FGM/C in the training of teachers and to send students into the rural areas.

To send the student in the rural...and before they go to rural they need some sort of training...Even in the curriculum, they can show about this, they can speak about the dangers of this. (F17)

A woman from a local NGO suggested the Child-to-child approach, and to educate children who could then teach their parents and other children. (F17)

Many people asked for sessions or lectures by a particular religious leader who is well respected by both Beja men and women. He is known for being against FGM/C.

...the famous religious man in all this state, he is Sheikh M T N....and he could start to do the lectures in the area. And after, he could train some people, to speak about this issue and the message, and they can take it to the community...(M16)

And for women, he can convince them, even me, he can convince easily....he has evidence for everything. Because he is a folk man, a religious man, and he is from the area, Beja....And also his age, when we say he is an old man, he is 70 years, and he has a nice speech....and he is good speaker in Beja language. And he can speak polite, in polite way with the people, for that all the people accept him (16- female translator)

Other

The following are remarks that did not fit into any of the above categories.

Some people emphasized the active role of the community:

Intensive learning for all the community (FQ9)

All the community has to collaborate (FQ9)

Health education and empower the women against it (FQ9)

One woman thought about people's fear of stigmatisation and shame.

To do lectures for all the community so as not to feel shame when someone decides not to do (FQ9)

Successes elsewhere

Some respondents reported of the methods and indicators used in an abolition programme in Haleib Province:

The women themselves they established societies, so as to lead the community to fight this. Even they discussed with the men in the other areas not to do this and not to make it for their girls.... And each village and group of women they did this swearing not to do for their girls. These 3 indicators.... 1. swearing 2. societies 3. discussion with men...(M16)

Other needs

Some respondents pointed out that they also had needs in other area, such as sanitation, waste disposal, and education:

And the shortage of education is a problem, and this shortage of the goods, the hard economic situation lead to no education because people do not send their children for education...(F4)

...first of all, our area is very dirty, yes, and the women here need awareness raising about all these issues, especially FGM but as you see the women also need other things in the area. The community needs other things in the area. Some families they have no latrines in their houses, no services, and a lot of rubbish in the area, they need to clean it. Even if we clean our houses, outside it is dirty ... (F1)

Against a programme

Negative or pessimistic statements reading a programme were given by 27% of men and 13% of women:

No way to fight because it is Sunna (MQ9)

We are Muslims we do not recommend to stop (MQ9)

Impossible to stop (MQ9)

Everyone in the community has the right to do whatever he wants (FQ9)

No way to leave it (FQ9)

If we don't do it, it is a sign of disbelief in God (FQ9)

We will not agree to stop it (FQ9)

5 Discussion

5.1 The practice

5.1.1 The procedure

Both women and men described the practice and immediate effects as traumatising and potentially fatal. Memories of the procedure if done at an older age were remembered from own experience. The horrifying aspect was still present, and it was overriding the

memories of presents and celebrations. The procedure as described by informants is usually performed without anaesthesia, and hygienic precautions are often absent. In this study, both women and men reported of immediate problems such as infections and bleeding. An older man gave an account on how his daughter bled to death after the procedure. Sequelae observed by health workers in Tagadom Hospital were infections, oedema and bleeding shortly after the procedure. These complications correspond to those published in the literature (Dirie and Lindmark 1999, pp 479-480). Longer-term problems that were associated with FGM/C included problems with periods, with urination, or problem arising from the scars, infertility, and psychosexual problems. Many women complained of unspecific pelvic pains, which could also be related to FGM/C. At Tagadom Hospital, problems resulting from scarring and inclusion cysts were commonly seen by doctors. All these complications reported by community members correspond to those described in older studies as cited in the introduction (Shandall 1967b, Aziz 1980b). A more recent study by Almroth (2005a, p.40) found a significant association between FGM/C and suspected urinary tract infection in Sudanese girls under seven. A case-control study by the same author (2005b, pp. 385-391) found a possible association between FGM/C and primary infertility. These accounts show that the practice of FGM/C is potentially harmful and can have long lasting effects, and therefore contravenes any agreements under the human rights framework. Improved documentation of possible sequelae may assist in the development of local guidelines for treatment. The medical services for those affected should be improved and complemented by psychological support.

Of particular concern are also the harmful effects of the frequent re-infibulations after deliveries, or the re-circumcisions that women undergo irrespective of childbirth. In this study, FGM/C was explored in general and not focused on one particular aspect. Further research of the practice of reinfibulation and recircumcisions amongst the Beja could contribute to the overall understanding of FGM/C.

Reportedly, celebrations of circumcisions are now less common. This could indicate a change of general attitude towards FGM/C. There are also reports of families who do celebrate but pretend to cut, and of those who do the procedure in secret. Both seem afraid to stand out, and they conform to their assumed public opinion. Avoidance of

stigmatisation and compliance with the norms are important within the Beja community, as will be discussed later on.

5.1.2 Age

FGM/C is usually performed on girls between the age of 7 days and 5 years. It seems that the practice of circumcising so soon after birth is particularly associated with the Beja.

Berggren (2005a) in her study in a village in central Sudan found that FGM/C was predominantly performed between the age 4 and 7 years. According to the Sudan Organisation against Torture (SOAT 1999), most girls in Sudan are circumcised between the age 5 and 10 and "reports of babies undergoing FGM were rare, with the exception of the Beja tribe in Eastern Sudan where infants of a few days, to a few months have undergone FGM/C".

Lightfoot(1991c) found that across Africa, FGM/C is practiced at earlier ages. One of the reasons given is that "a young child is far easier to manage". Hosken (1993i, p.35) noted that FGM/C "seems to be occurring at earlier ages in several countries because parents want to reduce the trauma to their children. They also want to avoid government interference and/or resistance from children as they get older and form their own opinions".

In this study, women also said that older children would feel more traumatised and it would be more difficult to handle them. However, it seems that the Beja have always circumcised their girls at a very early age. Rather than being an initiation rite, the practice may also be founded in their health beliefs and serve to protect the child from various diseases, as will be discussed later on. Implications would be to introduce or improve measures that will "keep the newborn safe" as requested by a male participant.

5.1.3 Prevalence and incidence

It has been estimated that 89% of women in North Sudan have been circumcised (UNICEF, 2006e). Specific data on prevalence amongst the Beja are not available

though a high prevalence of FGM/C has been confirmed by anecdotal reports from within the Beja community. Unfortunately, the quantitative data collected in the delivery ward of Tagadom Hospital did not allow any conclusions regarding the overall prevalence of FGM/C.

However, data collected at Tagadom Hospital, indicate a high proportion of infibulation. Of those with who presented to the delivery ward and gave a history of FGM/C, 84% were infibulated, which would correspond to figures for North Sudan published by UNICEF (2006f).

The collected data also showed that the number of women with FGM/C exceeds the number of Beja women attending for delivery. Assuming that this result is not due to errors in data collection, it raises the suspicion that women from groups not known to practice FGM/C may have adopted this practice. According to a report on FGM/C by the U.S. Department of State (2001b), "some southern women who are married to northern men and live in the north part of the country, elect to undergo the procedure". Parker (1995, p. 518) speculates whether this could be "a way of affirming their identity with dominant Arab and Muslim populations of the north".

Incidence of FGM/C in the study area could be estimated more reliably. Reports of new cases were collected by the Home Visitors in the community. The Home Visitors seemed sure that they would receive all the information about new cases in their areas of responsibility, which usually includes about 400 households. They seemed certain that they had not missed any cases unless FGM/C had been performed outside Port Sudan.

During the observation period between October and 2006 and Mai 2007, the number of new cases of FGM/C increased towards the beginning of 2007 with peaks in February and April. A common explanation for this seasonal variation was that the wound of FGM/C is believed to heal better if it is neither both too cold and wet, nor too hot. Therefore, the best time for the procedure is thought to be after the rainy and before the hot season. However, it is not known whether these numbers compare equally to the previous years. Another presumption would be that people knew that MSF was planning to start a program and mobilise the community. Therefore, it could be possible that some

families were worried that they may get "brainwashed" and tried to circumcise their girls before the implementation of the programme.

In addition, the data suggested that Type III was less prevalent amongst new cases than amongst adult women presenting to the delivery ward. In order to draw conclusions and decide whether the differences are statistically significant, a longer observation period would be necessary. If confirmed, it could indicate a shift from infibulation to less invasive forms, as has also been observed by Berggren (2005b) in her community study in Sudan. However, in view of the potentially harmful effects of any form of FGM/C, it remains questionable whether this is a positive development.

5.1.4 Decision structures

The decision making process seems complex. Both women and men considered mothers and grandmothers as the most important decision makers regarding FGM/C. Men placed themselves second together with the grandmothers. It seems that men considered themselves more important in this decision-making process than perceived by the women. An explanation could be that men referred to their role as sole decision makers with regard to circumcision of boys.

However, women mostly do seek the men's approval once they have made the decision with regard to FGM/C. If the man does not agree, he will try to convince the women. In the end, the "strongest" and the one with the best arguments will win. Some women said that they had not learned how to argue and lacked good arguments.

Almroth (2005c, p.31) found similar results regarding decision-making though did not explore the specific role of the grandmother. The role and power of the grandmother has been discussed by Dorkenuu (1995) who argues that "older women have an interest in preserving the lineage in order to preserve the stability of the family". Older women are often respected as much as men are, and it is only at advanced age when "they would seem to approach full membership in their husband's and son's patrilineage that they display an increasingly keen interest in its welfare and continuity".

Berggren (2005c, p. 28) who did a study on FGM/C in a village in central Sudan reported a "complex decision-making process, in which the different agents blamed the persistence on each others". Blame was especially directed against the grandmothers and midwives. In this study, some women expressed blame towards the midwives. Only on one occasion, a younger woman reproached the older women. Resentment however, was felt regarding the lack of communication between the sexes, as women and men very rarely speak about "women's issues" and FGM/C in particular. This has also previously been described by Rushwan et al (1983).

In terms of programme development, older women could be an important target group. During the interviews, they seemed to lack knowledge of basic medical facts and often expressed their wish for more education on health. They also complained of lack of interest and care by the medical profession. Medical services for older women with emphasis on "women's issues", would not only improve their health but also provide an opportunity for general health education and discussions about FGM/C.

Communication amongst women and men and between the generations could be encouraged and facilitated. In some programmes, the degree at which communication about FGM/C takes place has served as an indicator for success. This will be further discussed under 5.4.

5.1.5 Performers

The performers of FGM/C as indicated by respondents are mainly midwives and traditional birth attendants (TBAs). Home Visitors data of new cases showed that 64% of FGM/C procedures were done by midwives and 36% by TBAs. This corresponds with figures compiled by UNICEF (2005e) based on data from the DHS 1989/90 and MICS 2000.

Interview responses showed that in contrast to the above data, more people identified the TBAs as main performers. However, it was not explored, whether the distinction between midwives and TBAs is always clear for community members. It could also be speculated that some people may try to protect the performing midwives as they may get difficulties with their professional bodies.

Men referred to "others" more frequently. Clarification regarding "others" during interviews suggested either family members, or doctors as performers. It was said that older women sometimes performed FGM/C. It was also proposed, that men could have misunderstood the question and referred to male circumcision, which is mostly performed by doctors. Although the medical profession's involvement and so-called medicalisation of FGM/C has been reported in Sudan, this could not be confirmed for the Beja.

The practice of FGM/C guarantees a good source of income for TBAs and midwives, sometimes even for the families who arrange it. Income does not only derive from FGM/C in girls but also from the countless de-infibulations and re-infibulations before and after deliveries. Though not reported during the interviews, it is common practice in Sudan for some women to have regular re-circumcisions, even if not giving birth, with the aim to re-create a state similar to virginity.

The implication for a programme could be to identify the performers, and offer training and/or alternative income. The approach to empower the excisors and use as change agents has been tried in several countries. However, the conclusion of a systematic review of FGM programmes by WHO was, that "while excisors should be included in programming, finding alternative income for excisors should not be the major strategy for change". Focus on the excisors would not change the social convention that created the demand in the first place. In the project that developed out of the study of Sahl et al (2004) in Haleib Province, TBAs were invited to participate in income generation activities without the condition to abandon the practice. Within two years, 21 TBAs had stopped performing FGM and found new ways of making a living. However, this strategy was part of an overall approach that included all members of the community.

During the short time of this study, it was not possible to meet or interview any of those midwives or TBAs who were performing FGM/C. Other midwives and TBAs showed substantial interest in further training. Offering training opportunities for the performers could be a way of entering into a dialogue to get additional insight into their motives and generate ideas for future programming.

5.2 Reasons for the practice and continuation of FGM/C

5.2.1 Cultural heritage

Tradition and custom have been most frequently cited as reason for the practice of FGM/C. This correlates with descriptions in the literature as already indicated in the introduction. Women in the study stated how non-compliance with this tradition would result in stigmatisation and shame.

Although many are aware of the harmful consequences of FGM/C, the prospect of shame and social exclusion may be considered even more harmful. Parents were concerned that their daughters if not circumcised might get the reputation of "doing shameful things" and may not find a husband. Dorkenoo (1995, p.46) claimed that "women receive social approval when they undergo FGM and gain certain benefits: being marriageable and thus having access to resources in the community. Because of the social approval, and the sanctions women face if they do not undergo FGM, they inevitably end up viewing it in a positive light". According to Toubia (1995d, p.35), the fear of losing these benefits "is one of the greatest motivators of conformity" and that in order to comply with the demands of conformity, women would deny their individual needs and allow their bodies to be damaged.

In a recent publication by UNICEF (2007), it is recommended that FGM/C should be approached in the context of the social dynamics and conventions of their communities. Social convention theory as described by Schelling (1960) may help to understand why women are in favour of the continuation of FGM/C despite the adverse effects, pain, and suffering they have experienced themselves. Discontinuation may result in loss of status and protection and decreases the chances of marriageability. If one family alone decides not to practice FGM/C, they may not get their daughter married. However, if they convince other families to abandon FGM/C, they will again increase the chances of marriageability. As one woman stated during the interviews:

...if some houses together decided not to do it, it can be easy for them; but if one says that I will not do it, although all the community does it and wants to do it, this is difficult (F12)

Schelling has postulated that in order to abandon FGM/C, a "critical mass" of people who have abandoned the practice is necessary to reach the so-called "tipping point". Once this point is reached, a new social convention has been created, and not being circumcised will no longer be associated with stigma.

(Sahl et al, 2004c) did a study on the socio-cultural aspects of FGM/C amongst the Beja. They found that the practice of FGM/C has become a "silif" which is a "tribal convention and/or customary law that is immensely respected by all members of the community". Adherence to this law is not negotiable, and individuals who break it, will be socially excluded. They concluded that, to eradicate FGM/C, it would be necessary to formulate a new "silif". In the project that resulted from their study this was achieved through community discussions and dialogue.

5.2.2 Health and Hygiene

Health and hygiene were both noted as an important factor for the continuation of FGM/C and commonly mentioned in both the interviews and the open-ended questions of the questionnaire. FGM/C is assumed to keep healthy and prevent from various forms of illnesses. This is especially important in small children, and it may be the reason why circumcision is commonly performed shortly after birth. It is often the first treatment if a child is not thriving or suffers from some childhood disease, especially skin or eye diseases. It will keep a girl and woman healthy in general, but especially during pregnancy and delivery. It is also believed to have some mechanical function by preventing the fetus from falling out, and protecting against uterine prolapse. Infibulated women were afraid that defibulation would make them more prone for infections. Men in particular thought that the clitoris itself was a source of infection and therefore needed to come off. Women stated more frequently than men that FGM/C was important for hygiene and cleanliness, and some considered it essential for their beauty. Some people said that FGM/C was good for the liver, or that it prevented anaemia. A very popular belief was that FGM/C protects against the bites and venom of insects, scorpions, and snakes.

Specific health beliefs with regard to FGM/C are not frequently described in the literature. Koso-Thomas (1987, p.9) reports of claims that circumcised girls would be more healthy and that FGM/C cures all sorts of mental illnesses. Toubia (1995c, p.37) mentions health beliefs with regard to improvement of fertility, maternal and infant mortality. Hosken (1993j, p.41) reports that especially in Sudan, FGM is associated with cleanliness and hygiene. As the female genitals are regarded as "dirty", a circumcised girl or woman will be clean and therefore healthy. The same arabic word "tahir" is used for both cleanliness/purification and circumcision. In the "Encyclopaedia of Women & Islamic Cultures" (2005, p. 34) North Sudanese women are described as "pure" and marriageable if their bodies including the genitals are smooth without any surface impurities, and purity and cleanliness are associated with beauty.

Some respondents mentioned that children needed to be protected from evil spirits and the evil eye. Fadlalla (2002), an anthropologist, who explored perceptions of disease amongst the Hadandowa, a subgroup of the Beja, found an underlying "set of beliefs in the evil eye, spirits, and mysterious diseases, whose explanation lie in the social construction of "foreignness" and its threat to procreation and well-being". Women were perceived as more "porous" and susceptible to evil, especially in relation to their sexuality, menstruation, childbearing, and breastfeeding.

Sahl et al (2004d), also describe how uncircumcised Beja girls are believed to be vulnerable to evil spirits.

Jacobsen, in his study of "Theories of Sickness and Misfortune Among the Hadenowa Beja of the Sudan" (1998), described how spirits, either good or bad, play an important role in everyday life. He observed that uncircumcised children were believed to be especially vulnerable to spirit attacks. Therefore, circumcision served as protection, and to promote health. His finding that some insects and animals that attack humans are believed to be spirits, could explain the assumed protective effect of circumcision.

The Beja seem unique in their health beliefs with regard to FGM/C, insofar as benefits of this practice are also perceived in areas unrelated to female reproductive health and sexuality. The misconceptions about health are an important factor for the continuation

of the practice of FGM/C, and should be addressed in any future programme. Education with a focus on reproductive health issues and childhood diseases could be of benefit for the whole community. Especially, the older women seemed to lack basic knowledge, and were very interested in getting more information. It should be acknowledged, that most families have the best intentions when submitting their children to this practice, as it is believed to offer protection. The role of myths and spirits could be explored further, and whether FGM/C could be replaced by non-intrusive rituals that could serve for protection.

5.2.3 Psycho-sexual reasons

In this study, women claimed frequently that they practice FGM/C because they assume that men prefer it. They thought that it increases male pleasure during sexual intercourse, and will therefore increase marriage prospects and help to maintain a good relationship. Only a few men confirmed this, and some actually stated that they would prefer uncircumcised women. Almroth (2005d) reported a similar finding from his study in a Sudanese village: More of the younger men would have preferred to marry a woman without FGM/C. In his study, a number of men even gave account of male complications such as injuries to the penis because of the difficult penetration, and they felt adversely affected by their wives' suffering. In this study, some men also said that they would not object defibulation or non-reinfibulation after delivery if found beneficial for the health of their wives.

However, in their responses to the questionnaire and during the interviews, men did frequently mention women's sexuality, saying that the aim of FGM/C was to reduce the female libido and therefore prevent women from "doing shameful things". According to Hosken (1993k), it is believed that women are unable to control their sexuality and that the origin and control of this desire is located in the clitoris. If a woman cannot control her sexuality, she may lose her virginity or become unfaithful, and this will result in damage to the family's reputation and honour. El Saadawi (1979) argued that any children fathered outside a marriage could "lead to confusion in descendance and inheritance". Men wanted to ensure that they inherited their property to their own

children, and therefore she proposed that the ultimate reason for FGM/C could be economic interest.

During the interviews, women agreed that FGM/C does not give a guarantee for faithfulness, as pointed out by one woman:

...she can do, as she wants and then can infibulate again...

Overall, it seems that there are misconceptions and misunderstandings between women and men regarding the value of FGM/C in terms of sexuality. Both women and men make assumptions that were not confirmed by the opposite sex. However, as discussed previously, women and especially men may have felt uneasy to talk about their own feelings and sexual preferences.

An implication for the future would be to facilitate discussions amongst and between both men and women and help them to re-evaluate their assumptions.

5.2.4 Religion

Religion as reason for FGM/C was far less mentioned than expected. Although it ranked as second most frequently chosen option amongst men in the questionnaire, overall numbers were small. Women preferred this option even less. Almroth (2005e), in his community-based study in Sudan - though not amongst the Beja - also found that religion seemed to have less impact on FGM/C than tradition and social influences.

Both women and men usually gave short statements, such as: "it is from our Sunna". The term "sunna" is used both in religion and to describe a form of FGM/C, and therefore implies an association between the two. However, as discussed in the introduction, there is debate whether Mohammed referred to FGM/C and what exactly he said. Both women and men expressed their wishes for further information and clarification by a respected religious leader.

5.3 Attitude

5.3.1 Attitude towards FGM/C

Attitude towards FGM/C was assessed through observations, the readiness to discuss FGM/C and through specific questions. As mentioned previously, some people welcomed discussion with great interest while others were very reluctant to talk about FGM/C. The impression was that those women who attended the group interviews seemed to enjoy the opportunity to discuss women's health issues. Usually women and men do not discuss FGM/C together. Men often said that FGM/C was a "women's business", and that they would not talk about it. About a quarter of both men and women declined to participate in the questionnaire-administered interviews.

Several authors have suggested that one of the successes of a FGM/C programme would be if FGM/C would not any longer be considered as taboo, and if both women and men would discuss FGM/C together in public. Izett and Toubia (1999b, p.79) proposed that "increased public discussion" could be used as process indicator. UNICEF (2005f, p. 25) stressed the importance of "facilitating dialogue and non-judgmental discussion". GTZ (2007) stated that in their FGM/C project in Guinea the listening and dialogue approach turned out the most effective intervention. As a result of CARE's FGC abandonment projects in Kenya and Ethiopia, public discussions about FGM/C by women and men increased (Rajadurai and Igras, 2006, p.19).

To encourage discussion between women and men was also one of the strategies applied by the project that followed the study of Sahl et al (2004f, p.21). This open debate not only changed attitudes towards FGM/C but also helped them "to recognise the need for changing their living conditions....and empowered them to seek the necessary resources...".

The implications from the above would be to further encourage and facilitate dialogue amongst members of the Beja community. Whilst initial discussions would be amongst women and men separately, and in closed spaces, the aim would be to discuss FGM/C openly in mixed groups.

Attitude was also assessed through specific questions, which revealed that about half of women and men were against the continuation of FGM/C and would not circumcise their daughters in the future, and vice versa. As previously discussed, these estimates should be interpreted with caution as questionnaire results did not take into account the numbers of those who refused to be interviewed. It could be that people who are against FGM/C would be more willing to speak out and less likely to refuse to be interviewed. Therefore, their opinions could have been overrepresented in the study.

However, keeping these reservations in mind, the results still show a substantial number of people against FGM/C. The reasons mostly stated were the adverse effects on the health of women, including psychological well-being and sexuality. Some men referred to FGM/C as mutilation, sadism, or torture. In terms of tradition, it was just an old habit, not worth of continuation. Some said that it was not prescribed by their religion. Others insisted that FGM/C originated in Egypt and therefore had to be regarded as a foreign habit. Furthermore, the unlawfulness and illegality of FGM/C was mentioned. Some claimed that the midwives, by making profit, were the sole beneficiaries of this practice.

Personal stories during the single and group interviews also gave an account of how families had changed their attitude and/or stopped the practice. This did not only apply to new circumcisions but also to re-infibulations after deliveries. Two young women, who were interviewed a few weeks after their deliveries, had both refused re-infibulation and felt that it had a positive impact on their health. Women stated that they had "started to think and fight" or been encouraged by others who had stopped. As previously pointed out, amongst those who practice FGM/C, a shift from infibulation to less severe forms may also have happened. This development could be part of a national declining trend in prevalence that was reflected in the recent unpublished household survey. Almroth (2005f), in his community-based study in Sudan, also reported a change in attitude.

The overall aim of this study was to develop strategies that would empower women and men to abandon the practice of FGM/C. In order to develop those strategies, it seemed

important to make an assessment with regard to people's readiness to change, and to find out first, if such a programme would be welcomed and supported.

Local community leaders were mostly against all forms of FGM/C. However, most local religious leaders, though condemning the practice of infibulation, still expressed support for "Sunna" circumcision". All leaders assured their support for a future programme.

The results from the study suggest that change with regard to FGM/C/ has already started to take place. Each of the stages of change, as described by the Transtheoretical Model of Behaviour Change, was found represented in individuals within the Beja community. Developed by DiClemente and Prochaska (1982), this model proposes that behaviour change occurs in five stages through which people move: Pre-contemplation, contemplation, preparation, action, and maintenance. Although this model may have limitations in its application to collective change, Izett and Toubia (1999c) suggested that with regard to FGM/C, identification of a particular stage, and of those factors that either advance or hinder progress, might help to develop intervention strategies.

The model of "diffusion of innovations" (Rogers 1962) describes change within groups rather than individuals. It proposes that new ideas, beliefs, and behaviour are first adopted by "innovators". This new behaviour will then gradually diffuse within a community until a critical mass of adopters has reached. From then on diffusion will accelerate, and once the majority had adopted the behaviour, it will become the norm.

The Positive Deviance Approach is a similar model that builds on individuals, who have "deviated" from conventional norms and developed an alternative belief or behaviour. For example, those parents or leaders who refuse to circumcise are identified and offered training to become change agents and to advocate against FGM/C in their communities (Masterson and Hanson Swanson, 2000).

In this study, several so-called innovators or "positive deviants" were identified: Both women and men who were against FGM/C and had the potential skills to take a lead in the facilitation of community dialogue.

5.3.2 Ideas regarding an FGM program

The variety of ideas and suggestions regarding a future programme exceeded all expectations. Literature review did not identify any studies with a similar question for comparison of results.

A surprising result was also that a substantial number of those who were for the continuation of FGM/C, still made suggestions for a future programme. It could be assumed that they had entered the stage of contemplation, which according to Izett and Toubia (1999), is characterised by "growing awareness or interest, questioning knowledge and beliefs".

Most suggestions focused on awareness raising with regard to health and medical issues. This could have been biased due to the research team's affiliation with the local hospital and medical organisation. However, in view of the findings during the interviews, this is more likely to represent a real need. Most people wanted more information about the harmful consequences of FGM/C. In addition, some, especially older women, also expressed the wish for general health education and improved health services. In the past, the Beja have had the reputation for not using health services unless in a terminal state, so this may also indicate change and openness to innovation.

A number of people, and surprisingly more women than men, asked for religious lectures. It could be assumed that women have less opportunity to visit such events than men do. Although they were not very specific about the content, it can be assumed that people wanted clarification regarding the Prophet Mohammed's sayings. However, some were very specific about a particular speaker.

People usually wanted speakers or lecturers of some authority, such as leaders of community, tribe, clan, committee, or religion. It was important for many that those would be Beja and speak the local language. An exemption was made for "white people" who are hold in high esteem. Others suggested training of schoolteachers, the Home Visitors, students, or children as trainers.

The different methods, tools, and places that were proposed by participants demonstrated a lot of creativity, e.g. playing cassette tapes in the local rickshaws, or using the women's weekly coffee parties for awareness raising. Some had very specific ideas regarding a local radio programme.

Groups and people suggested as targets for a future programme included almost everybody. Participants stressed the importance of focusing on both women and men, and on different generations. Particular attention should be paid to grandmothers, and children and adolescents should be addressed in schools.

Midwives were also identified as target group for training though some respondents also called for stronger laws and punishment of the midwives. Others asked that the government and NGOs should make public statements and condemn FGM/C. There was also the proposal to include a message regarding FGM/C in the birth certificate.

In summary, most people said that they wanted more education and information and suggested a range of information, education, and communication (IEC) activities. According to Izett and Toubia (1999), this interest and thirst for knowledge is again characteristic for the contemplation stage of the cycle of change.

However, according to the previously mentioned review of successful FGM/C programmes (Mohamud, et al 1999c, p.26), conventional IEC strategies are often not sufficient to facilitate change of behaviour. Behaviour change communication (BCC) on the other hand, aims at involving the communities in an interactive and participatory way. BCC encourages dialogue and discussions rather than delivering messages and may include skills building, e.g. assertiveness training and how to resist group pressure or deal with stigmatisation.

Some respondents though did propose a more active approach, such as "collective discussions", "speaking out in celebrations", "intensive learning for all", or "empowerment of women". It was also suggested that the Home Visitors would be a suitable group to engage families into dialogue on a day-to-day basis.

As the request for conventional health education derived from within the community in a participatory way, it should not be ignored. The best strategy may be to combine both IEC and BBC approaches in a complementary way in line with one of the WHO recommendation of successful programmes: "Programme implementers need to tailor their approaches to specific audiences; this requires a variety of programme approaches implemented in a strategic fashion." (Mohamud, et al, 1999d, p.30).

A lot could also be learned from a local NGO who did a very successful project in Haleib Province in the North of RSS that resulted in public declarations and oaths by whole villages to abandon the practice. Women are now looking forward to have girls so that they can be proud of them.

Last, not least, and as mentioned by some participants, it should not be forgotten that the Beja community has urgent needs in terms of water, sanitation, and waste disposal. Empowerment with regard to FGM/C may also boost the community's confidence to deal with those problems.

6 Conclusion

This study demonstrated that the reasons for the persistence of FGM/C amongst the Beja are based on a multitude of socio-cultural factors. Adherence to social convention, the fear of shame and stigmatisation, and deep-rooted beliefs and assumptions with regard to health, sexuality, and religion are important aspects. In order to develop strategies that promote abandonment of FGM/C, those factors should not be viewed in isolation. For example, addressing the beliefs and misconceptions about health alone, would not change the powerful rules of social convention. Those who continue with the practice are often aware of the harmful effects, as shown in many examples during this study. It has been argued that programmes that solely focus on the negative health consequences would promote the so-called "medicalisation" of the practice - the request for health professionals to perform FGM/C in order to minimise the risks.

Therefore, strategies aimed at abandonment should address FGM/C at different levels and use a variety of approaches. Based on the findings from this study and the different models of behaviour change, a future programme could build on those who have stopped practicing FGM/C, the so-called innovators or positive deviants. Ideally, they would represent various stakeholders. As suggested by the participants of this study, they should initially come from groups such as community leaders, religious leaders, health professionals, schoolteachers, or the Home Visitors. During the interviews, several of those, who belonged to these groups and affirmed their commitment to abandonment of the practice, have been met. Together with others, they should be encouraged to become leaders and change agents in facilitating a dialogue within the community. If necessary, they should be trained according to their individual needs. This training could provide information on medical or religious issues, or development of skills with regard to communication or conflict-resolution. These leaders should then facilitate non-judgemental discussions within the community to address the misconceptions and underlying beliefs about health, sexuality, or religion, as identified in this study. Based on observations and statements during the interviews, it would be recommended that initially, women and men should hold separate meetings. However, the aim would be a dialogue between women and men, and all generations, including older people and adolescents. As recommended in the literature, public discussions between both women and men, and public declarations could be used as indicators of success.

Conventional IEC activities using various audio-visual media, as suggested by the participants of this study, should complement this approach. A radio programme about FGM/C in Beja language, hosted by community members, a mobile theatre group, or videos, tapes or pictures could be used to initiate discussions about FGM/C. As requested by many community members, a respected regional religious leader should be invited for lectures, and health education sessions by medical experts should be organised.

However, health professionals should also receive training to update their clinical knowledge and skills about FGM/C. Furthermore, their training should include communication and counselling skills, and they should be encouraged to integrate education about FGM/C into their daily routine.

A specific group to be targeted in this programme should be older women. This study has shown that older women play an important role in the decision-making process and the perpetuation of FGM/C. Improved health services with a focus on older women's health could provide an opportunity for general health education and discussions about FGM/C. Those who have stated their commitment to abandonment of the practice, such as some of those encountered during the interviews, should be empowered to become activists and leaders in the campaign.

It is crucial to involve men in programme activities. This study showed that men often are the final decision-makers with regard to FGM/C. Some women gave examples of men who did not consent to the circumcision of their daughters. Also those men who have the courage to say that they prefer women uncircumcised- like one participant in this study- could become change-agents and challenge other men in their beliefs.

Based on the recommendations by some participants, the youth should be specifically addressed and actively involved in any programme activities. Those schoolteachers, who are against FGM/C, could raise awareness and initiate debates about health, human rights, and gender issues. Young people should be encouraged to become educators for their peers.

TBAs and midwives who are suspected to perform FGM/C should be invited for discussions to find out their motives for the continuation of the practice. They should be offered to join training activities at the local hospital. Additional income generating activities could be explored, however should not be the predominant strategy.

To get a better estimate of prevalence, FGM/C should be linked to ethnicity and could be documented in both antenatal and delivery care consultations. Data on incidence should include the age of children to confirm the present findings. The criteria of possible complications of FGM/C should be defined and documented, and could serve as a basis for further research. In terms of a programme, it could be considered to offer medical and psychological support to those women who have suffered from the sequelae of FGM/C. This would include counselling on defibulation and future non-reinfibulation

after deliveries. Postnatal health checks and immunisations should be used for surveillance of infants and opportunistic health education.

Further studies should explore the particular beliefs surrounding reinfibulation, and the fears associated with non-reinfibulation. A follow-up study of women who agreed not to be reinfibulated after delivery could provide further valuable information. As this study was not as representative for men as for women, a qualitative study with a special focus on men's role with regard to FGM/C could provide additional insight. A KAP survey could be useful as a monitoring tool.

Further strategies should include lobbying of governmental bodies and demand for support through policies and laws. The local Ministry of Health should make a public statement regarding FGM/C, and should improve training and monitoring of midwives and TBAs. The Ministry of Education should include FGM/C in the training of teachers and improve access to schools, especially for girls.

The role of NGOs should be to assist the community in organising themselves. They should provide logistical and financial resources to create a supportive environment for capacity building, empowerment, and change. Approaches to abandon FGM/C should be linked to efforts to improve the general living conditions in the shanties and to eradicate poverty.

The overall aim of this study was to develop strategies to empower the community to abandon the practice of Female Genital Mutilation/Cutting. The findings and recommendations of this study were included in a project proposal that has already been accepted. It may take time to change beliefs, attitude, and the practice of FGM/C. As one man stated: "You cannot change it in a day or night". However, this study has also shown that change has already started and will conclude with the remark of an older woman: "This is our time, my daughter... this is a new time for the women.

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8 Annexes

8.1 *Topic guides for the interviews*

Single and group interviews with women:

The practice

How is it done, when, who does it...? Who takes the decision? Do women and men discuss FGM/C together? Are there any ceremonies with FGM, or alternative ceremonies if they don't circumcise?

Are women aware of the Zero Tolerance policy (no re-infibulation after deliveries) at Tagadom Hospital? Would they deliver at TH? Re-infibulation and non-re-infibulation after deliveries - are men involved in this decision?

Reasons, beliefs

What are the reasons for FGM/C? What do you think is good about FGM/C? What do you think is not good about FGM/C?

A future programme

Do you get any information about women's health issues? Would you like to learn more about women's health, and/or FGM/C? What do think about a programme, and do you have any ideas regarding a programme?

Other

Relationship between women and men

Marriage/divorce, contraception, sexual violence, women's health

Single interviews with women who were not reinfibulated after their deliveries

What do you think about the Zero tolerance at Tagadom Hospital? How is it for you not to be resutured? How does your husband feel about it? Does he know? Would you circumcise your children in the future?

Meeting with women to follow-up some issues from the questionnaire

Why is FGM/C good for health? Do you discuss FGM/C with your men? Regarding decision making - any explanation why women and men answered differently?

Men said that they supported FGM/C to ensure that a woman stays faithful - what do you think about this?

Interviews with the Home Visitors:

1st focus group:

What are the problems in this area?

2nd focus group:

What do you think about FGM/C? Please write one or two sentences on a piece of paper - anything that comes to mind.

3rd and 4th meeting (follow up after the first round of questionnaire interviews):

How did it go with the interviews and questionnaires? Any problems? Any comments? Any suggestions?

What do you think about a programme that focuses on FGM/C? What would be important for such a programme? How do you see your role in such a programme?

Which support would you need?

Interviews with men:

Do you feel comfortable to speak about FGM/C? What do you know and think about FGM/C? What are the reasons for FGM/C? What are the benefits for the women?

What do you think of a programme? Would you support it? Do you have any ideas for a programme

Interviews with key persons from NGOs, GOs and MOH:

What do you do, are you involved with FGM/C, and if yes how? What do you think are the reasons for FGM/C amongst the Beja? What do you think of a programme here in Port Sudan?

8.2 Questionnaire on FGM for women and men in the Beja Community

Location: _____

Date: _____

Age: _____

Sex: _____

1) What are the reasons for FGM in your community?

Please tick one or several of the following options:

Tradition	Religion	Husband's preference	Hygiene	Other

2) Who takes the decision about circumcision in you family?

Please tick one or several of the following options:

Mother	Grandmother	Father	Grandfather	Aunt	Other

3) What are the women's benefits?

4) Do you think that FGM should be continued?

Please circle your chosen answer.

Yes

No

5) If yes - why? If no - why? Please give the reasons for your answer to question 4.

6) Would you have your daughters circumcised in the future?

Please circle your chosen answer.

Yes

No

7) Who does circumcision for the children in your community?

Please tick one or several options.

Village Midwives	TBAs	Other

8) How could FGM be eradicated in the community?

8.3 List of interview recordings

Table 12: List of recordings

No	Recording	Interviewees	Date	Length of recording (hh:min:sec)
1	WS 10026	Women's group Tagadom	27/3/2007	01:20:29
2	WS 10027 WS 10028	Women's group Onguab North Same	27/3/2007 same	00:20:08 00:33:31
3	WS 10039	Women's group Onguab South	18/4/2007	1:10:46
4	WS 10013	Home Visitors	25/3/2007	00:33:41
5	WS 10030	Home Visitors	29/3/2007	00:40:40
6	WS 10037	Home Visitors	8/4/2007	00:14:46
7	Ws 10038	Home Visitors	12/4/2007	00:29:41
8	WS10032	Men's group	5/4/2007	00:42:07
9	WS 10012	Home Visitors' manager (female)	22/3/2007	01:10:05
10	WS 10040 WS 10041	Home Visitors' manager (female) Same	23/4/2007 same	00:05:52 00:06:09
11	WS 00019	Female A	26/3/2007	00:33:34
12	WS 00018	Female B	26/3/2007	00:44:07
13	WS 10014	Male A+B (consecutive)	25/3/2007	00:28:42
14	WS 10021	NGO (women's group)	26/3/2007	00:54:47
15	WS 10031	Director of Midwifery School (female)	2/4/2007	00:46:36
16	WS 10033 WS 10034	Director Ministry Social Welfare Same	7/4/2007 same	00:30:50 00:18:37
17	WS 10035	NGO (mixed group)	8/4/2007	01:14:11

9 Declaration of originality of work

This thesis is the result of independent investigation. Where my work is indebted to the work of others, I have made appropriate acknowledgements.

I declare that this study has not already been accepted for any other degree nor is it currently being submitted in candidature for any other degree.

14. Februar 2008 Rose Ansorge

10 Acknowledgements

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General Practitioner, London

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Reproductive Health Advisor, Port Sudan, for Medecins Sans Frontieres (MSF)
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March 2006 - February 2007

General Practitioner, London

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Medical Doctor, Leepa Valley, Kashmir, Pakistan, for Medecins Sans Frontieres (MSF)

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Preparation of a research project on iodine deficiency in Eastern Chad

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General Practitioner

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Medical Doctor, Farchana Refugee Camp, Eastern Chad, for Medecins Sans Frontieres (MSF)

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Lecturer in Women's Health as part of the Family Medicine Training Programme, University of Pristina, Kosovo for Bernard Brunhes International

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Study for Master's Degree in International Health

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Coordinator and Trainer/Clinical Supervisor in Family Medicine for World Health Organisation (WHO) in Kosovo

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Mother and Child Health Coordinator for International Medical Corps (IMC) in Gjilan, Kosovo:

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General Practitioner, London

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Medical Practitioner in Sexual Health, St. Ann's Hospital in London

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Medical Doctor for Voluntary Services Overseas (VSO), Mikumbune Health Centre, Meru District, Kenya and St. Joseph's Hospital, Kilgoris, Kenya

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General Practitioner, London

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Senior House Officer posts in Accident & Emergency, Obstetrics & Gynaecology, General Surgery, General Medicine, and Care of the Elderly, all U.K.
GP Registrar at Lower Clapton Group Practice, London

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Medicine at the Free University of Berlin

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Training and work as a Physiotherapist in Kiel and Berlin in Germany

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June 1988	State Exam Medicine Berlin
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July 1989	Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS)
Nov 1995	Diploma of the Royal College of Obstetricians & Gynaecologists
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