Ending FGM/C through Evidence Based Advocacy in Sudan

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1. Introduction:

Worldwide about 3million girls are at risk of undergoing female genital mutilation/cutting (FGM/C) and 140 million girls and women are currently living with its consequences. It is mostly carried out on young girls sometime between few days old to 15 years of age. In Africa an estimated 92 million girls 10 years old and above have undergone FGM/C (WHO, 2012).

FGM/C is practiced in about 28 African countries, the Middle East and South East Asia. Women and girls who have undergone FGM/C are also found in Europe, Canada, USA and Australia because of the increasing movement of communities and individuals between countries (WHO, 2012). The complications that may occur following FGM/C depend on the type and extent of the procedure carried out. These are generally classified as immediate, intermediate and long-term complications.

In the Arab region, FGM/C is common in Sudan, Egypt, Somalia and among some groups in the Arabian Peninsula (in Oman, United Arab Emirates, Yemen); Iraq; occupied Palestinian territories (UNFPA 2012). In many of these countries and for many years diverse organizations at all levels have worked in a variety of campaigns with the common aim of abolishing this harmful practice. Experience over the past two to three decades has shown that there are no quick or easy methods that can bring change. However, lessons show that in order to have effective results and create a change in the practice of FGM/C, there is a need for evidence based, sustainable interventions that target and involve different players in the community, especially men.

The UNFPA and UNICEF Joint Programme works on many levels - from advocacy to influencing legislation - to accelerate change for the abandonment of FGM/C. Launched in 2007, the programme works in synergy and partnership with national governments civil society, religious leaders, communities and key stakeholders to support community-based and national activities that have been identified as leading to positive social change through previous evidence. The program carefully adopts an innovative approach by building on on-going programmes and not being a stand-alone initiative and aims to achieve a 40 per cent reduction in the practice of FGM/C on infants and girls up to age 15 by 2012. Many reports have been generated using existing statistics and lessons from the ground to inform plans and to improve understanding of related issues in the wider context of gender equality and social change.

This paper will reflect on some of the lessons learnt from Sudan and focusing on how advocacy efforts in Sudan by different players have made use of existing statistics to examine differentials and trends in prevalence, and highlighting patterns within the data that can strategically inform policy and laws pertaining to FGM/C at different levels. It will also shed light on how national surveys in Sudan have evolved to respond to the need of

the campaign and how national and states mechanisms in Sudan have employed existing evidence to influence laws at national and states level.

2. Definition and international legal framework of FGM/C

The World Health Organization (2007) defines female genital mutilation/cutting (FGM/C) as the 'procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons'. FGM/C is often called *female circumcision* implying that it is similar to male circumcision. However, the degree of cutting is far more extensive, often impairing a woman's sexual and reproductive functions and even the ability of girls and women to pass urine normally. This is why the World Health Organization (WHO) refers to the practice as *female genital mutilation*, and *Female genital cutting* is also used, particularly where the apparently judgmental phrase *female genital mutilation* might offend and lead to resistance to change. The WHO has classified FGM/C as follows; Type I - Clitoridectomy: partial or total removal of the clitoris and, in very rare cases, only the prepuce; Type II - Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora; Type III - Infibulation: narrowing of the vaginal opening through the creation of a covering seal; Type IV - other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area (WHO 2012).

The harmful effect of FGM/C was recognized by the international frameworks, including the Convention on the Right of the Child (1990), the International Conference for Population and Development (ICPD) in Cairo 1994 and the Declaration and Platform for Action of the Fourth World Conference on Women (FWCW), Beijing 1995. After the ICPD and FWCW, the campaign against FGM/C gained momentum and wider support where it moved beyond being a national or regional concern, to an international one. It also attained a wider scope of being more than a practice with adverse health consequences, but an issue of women's sexual and reproductive health and rights. Moreover, the Programme of Action of the ICPD (1994) recognized FGM/C as a harmful practice meant to control women's sexuality have led to great suffering and is considered as a violence against women, a violation of basic rights and a major lifelong risk to women's health (para 7.35). It has therefore urged governments and communities to urgently take steps to stop the practice of FGM/C and protect women and girls from all such similar unnecessary and dangerous practices (para 7.40) (UNFPA 2012).

Moreover, also at international level, there are other efforts and mechanisms that have been developed to ensure the inclusion of campaigns against FGM/C in countries programs. These include;

- In 1958 the first international action on FGM/C, was taken when the Economic and Social Council invited the World Health Organization (WHO) to undertake a study of the persistence of customs subjecting girls to ritual operations and to communicate the results of the study to the Commission on the Status of Women.
- In 1960, the issue of FGM/C was debated at the Seminar on the Participation of Women in Public Life, held at Addis Ababa for the African region.
- This was followed by a seminar convened in 1979 by the WHO Regional Office for the Eastern Mediterranean in Khartoum, which marked a milestone in the campaign against harmful traditional practices, and a recommendation was made for the formation of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (www.soatsudan.org 2006).

Other recent international standards that include explicit prohibitions of FGM/C are;

- The UN Sub-Commission on Prevention of Discrimination and Protection of Minorities since the early 1980s.
- FGM/C was recognized as a form of violence against women in the UN Declaration on the Elimination of Violence against Women
- The UN Beijing Declaration and Platform for Action.
- A range of UN specialized agencies have more recently developed policies and programs on FGM/C, including the aforementioned Joint Program on FGM/C Abolition by UNFPA & UNICEF. In 2010 WHO published a "Global strategy to stop health care providers from performing female genital mutilation" in collaboration with other key UN agencies and international organizations.
- The Universal Declaration of Human Rights.
- The Convention on the Elimination of All Forms of Discrimination Against Women (Article 5 (a)
- The Declaration on the Elimination of Discrimination Against Women states (Article 2)
- The UN Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief (Article 5. 5).
- The Convention of the Rights of the Child states (Article 24 (1) & Article 24 (3))
- The Beijing Declaration and Platform of Action (para. 224).

At a regional level, the African Charter on the Rights and Welfare of the Child, adopted by the Organization of African Unity in 1990 contains a number of unique provisions, which relate to FGM/C (www.soatsudan.org/reports 2006; UNICEF 2005).

3. The Negative Developmental & Human Rights Aspects of the Practice of FGM/C

FGM/C is a fundamental violation of the rights of girls and women. It is a discriminatory act which violates the rights to equal opportunities, body integrity, health, and freedom from violence, injury, abuse, torture and cruel or inhuman and degrading treatment, protection from harmful traditional practices, and to make decisions concerning reproduction. These rights are protected in most of the international conventions and laws.

FGM/C causes irreparable harm. It can result in death through severe bleeding leading to haemorrhage shock, neurogenic shock as a result of pain and trauma, and severe, overwhelming infection and septicaemia. It is routinely traumatic. Many girls enter a state of shock induced by the severe pain, psychological trauma and exhaustion from screaming.

The health consequences of FGM/C seem to vary according to the type and severity of the procedure. Complications may range from immediate, such as bleeding and shock, to a wide range of longer-term problems for women and their newborn children. Psychological effects may be profound and permanent. Additionally, FGM/C may increase the risk of HIV or Hepatitis B, due to unclean conditions often associated with the procedure.

Recent studies on harmful effect of FGM/C on women and girls health have found clear relationship between FGM/C and maternal and child health problems such as increased incidences of caesarean section, long labour, postpartum haemorrhage, perineal injury leading to fistula, low birth weight, low Agpar score and perinatal death (WHO, 2006). Other harmful effects include: failure to heal; abscess formation; cysts; excessive growth of scar tissue; urinary tract infection; painful sexual intercourse; increased susceptibility to HIV/AIDS, hepatitis and other blood-borne diseases; reproductive tract infection; pelvic inflammatory diseases; infertility; painful menstruation; chronic urinary tract obstruction/ bladder stones; urinary incontinence; obstructed labour; increased risk of bleeding and infection during childbirth (Elmusharaf et al, 2006; Almroth et al, 2005a & 2005b).

Moreover, the mutilation is often performed under unhygienic conditions, without an anesthetic, by means of non-surgical instruments such as razor blades, knives, or broken glass. If performed without anesthesia, FGM/C is extremely painful. Short-term complications like infection can occur accordingly and result in fatal septicemia, tetanus, or gangrene. Long-term consequences include persistent pain, sexual dysfunction, chronic urinary tract infection, incontinence, and infertility. The resultant anatomical abnormalities may complicate childbirth, increasing both maternal and neonatal morbidity and mortality; a surgical procedure may be necessary to open the lower genital tract.

Genital mutilation may also impact on a woman's right to enjoy her sexuality to the full due to the profound negative effects the procedure has on the psychological and psychosexual development of a girl which, lasting into womanhood, may adversely affect her sexual life.

Currently, with the increase of the HIV/AIDS epidemic, FGM/C is recognized to pose a theoretical risk of increasing HIV transmission in countries where HIV prevalence is high. This risk could arise from the use of contaminated instruments, for FGM/C procedures or the management of FGM/C-related obstetric complications, or from genital tract trauma associated with intercourse.

The physical damages resulting from FGM/C, together with the psychological trauma and pain associated with it, can compromise an adult woman’s normal sexual life and self esteem resulting in constant marital problems that

can eventually lead to divorce which in our traditional societies can jeopardise women's social and economic status and that of their children, thus resulting in poorer families (UNICEF 2006).

4. The Current Situation of FGM/C In Sudan & How Data is Used to Change Law/Policy

The 1990 Sudan Demographic and Health Survey, showed that 89% of ever-married women in the northern, eastern and western provinces had undergone either Type I or II (15%) or Type III (85%) FGM/C. According to the 1999 Sudan Safe Motherhood Survey, there was a slight increase in FGM/C during the period 1990 – 1999, from 89% to 90% for women aged 15 – 49 years. Over 99% of women in the Northern State have been subjected to FGM/C, compared to 52% in Western Darfur State. Over 60% of women have been subjected to type III FGM/C and 22% to Types I and II in Northern Sudan (SMS 1999). The first Sudan National Household Survey (2006) showed a reduction in the FGM/C prevalence rate where the average one was 69% in the 15 Northern states, varying between 40% in West Darfur and 84% in River Nile state compared to a national prevalence of any type of FGM/C of 66% in the most recent Sudan National Household Survey (2010). It has also shown range of 84% in Northern State and 46% in West Darfur.

Most of the existing prevalence rates are based on self reports of respondents to surveys and many debate these figures and their ability to reflect the real situation on the ground. Evidence existing so far indicates a big discrepancy between types practiced and self reports by women and circumcisers. In two studies in Sudan, one done by Lars Almroth, found that at least half of the women who stated they had type I (clitoridectomy) and II (excision) FGM/C were actually subjected to Type III (infibulations) (Elmusharaf et al, 2006). Another study that was done among midwives, who were asked to describe in details the operation done in type I, gave details similar to types II and III (Abdel -Mageed 2001). Such studies and evidence they produced have informed the type of question in the SHHS on prevalence where the question was based on "any type of FGM/C" rather than on specific type. Moreover, this may have also influenced the overall national campaign where the National Strategy on Abolition of FGM/C of 2008 is focusing on all types rather than one specific type of FGM/C.

The reasons for the practice in Sudan do not differ from those in neighboring countries. Most respondents in social studies indicate reasons such as to maintain cleanliness, increase a girl's chances of marriage, protect her virginity, discourage "female promiscuity" thus preserving the family honor, improve fertility and prevent still birth. It is also believed to give the husband greater sexual pressure thus giving the woman more power allowing her to sexually manipulate the man in order to obtain material advantages. In a study by the Sudan National Committee Against Traditional Practices (SNCTP) it was shown that there is a general belief that during childbirth, the clitoris is dangerous and 'if the baby's head touches it, it will lead to its death' and in some areas, it is believe that if FGM/C is not carried out, the clitoris will grow to dangle between the legs like a penis. Moreover, Femininity is thought to be enhanced through the removal of "masculine" parts such as the clitoris, or in the case of infibulation, to achieve smoothness considered to be beautiful (www.soatsudan.org/reports 1999).

Religious reasons are often mentioned and are sometimes misused by pro FGM/C groups to sustain the practice. A common statement on the stand of religious leaders in Sudan is still a missing link that is hindering the efforts for the abandonment of the practice.

How Advocacy Groups Used Data to Generate Evidence Based Advocacy to Formulate & Change Laws/Policies

Experience shows that NGOs have typically been the key actors in designing and implementing successful programmes (UNICEF, 2006). In different countries, the combination of a health-based approach and new behavioral change strategies, such as peer education, use of positive deviants and community conversation, were used to build the capacity of a targeted population to combat FGM/C.

Evaluation and assessment of the impact of the different campaign approaches to abandon FGM/C has revealed that all approaches have some element of success in either reducing the prevalence or changing the behavior or knowledge of communities about FGM/C. The traditional medicalization approach has been the least effective while the alternative right of passage is more effective but the integrated approach is the most effective one so far. Campaigns against FGM/C take long to yield results and has to be part of a larger process of social change. Also studies showed that change will not necessarily happen everywhere and where it does happen, it may bring some resistance and setbacks with it. Therefore the existence of sustainable developmental programs and conducive environment through legal frameworks and policies may make communities and other stakeholders motivated to continue in the campaign for the abolishment of the practice beyond the life spans of mainstream projects and programs and to ensure they do not revert to their original practice.

Efforts against FGM/C practice started in Sudan in the early 1940s as indicated before, in a form of legislations banning the practice. However community awareness efforts started extensively in the 1970s by few non-governmental organizations. These efforts continued till present, where more groups joined in the campaigns including the government, UN agencies and other institutions including academic ones.

The National Plan of Action on FGM/C which was endorsed by the Ministry of Health in 2001, and the chapter on FGM/C which was included in the Reproductive Health Strategy by the Federal Ministry of Health, both have provided some sort of conducive environment for advocacy groups, including one of the FGM networks which was active at that time. The Sudanese Network for Abolition of FGM/C (SUNAF) was a key advocacy body made up of many NGOs and academic institutions. It was very active in the drafting of the strategies as well as in disseminating it amongst its members.

Moreover. at the federal level, a steering committee was formed to ensure the coordination among government departments, networks of NGOs and civil society groups. At state levels, there are councils and steering committees for FGM/C, while at the community level, community-based organizations brought together women's groups, religious leaders, midwives, community leaders, as well as children and youth to promote behavioural

change. Media campaigns were promoted at the federal and state levels, while at the community level, radio programmes featuring key community members are broadcast in local languages. The overall scope of activities included: Awareness raising, advocacy- law and penalties for circumcisers, capacity building, research and integrated community based projects.

Statistics produced from the main national surveys on FGM/C as well as some of the medical studies have been used widely by these groups in the following formats:

- As key information to draw the attention of policy makers on the magnitude of the practice especially in high prevalence states
- To identify and produce evidence on who should be targeted in campaigns, and data from the SMS, 1999 has contributed to the national focus on males and their involvement in the campaign
- Perceptions about why FGM/C practice should continue resulted in inclusion of key government officials and religious leaders in the campaign.
- People perform the practice was a key variable that have mobilized the medical legislators into drafting the famous Medical Council Statement which paved the way for the FMOH Strategy of 2001.
- Health impact of FGM/C was used to convince key decision makers on importance of drafting strategies and inclusion in policies such as the National Population Policy of 2001.

National Strategy for the Abandonment of all types of FGM/C (2208-2018): A Successful Story for the Use of Statistics to Shape Strategies

The review of the 2001 Plan of action and development of a National Strategy for the abandonment of all types of FGM/C which was lead by the National Council for Child Welfare (NCCW) have adopted a more comprehensive approach. This was through the inclusion of different groups including SUNAF, Academic institutions, line ministries and legal experts. A very thorough review of existing policies, legal frameworks at international, regional and national levels, and existing studies and surveys was done by the Technical Committee which drafted the strategy. A special part in the strategy reviewed these statistics and used major indicators as guiding points for the components and targets set by the strategy. The strategy was endorsed in 2008 with the vision of having a Sudan free from all forms of FGM/C within a generation by 2018 with the aim of total abolition and zero tolerance by addressing the religious, social, health, and cultural dimension of FGM/C.

Following the same pattern, the NCCW with other key ministries and councils, have drafted the Child Act Bill for adoption to include an article to illegalize FGM/C on health social and other grounds. Article 13 of the law which prohibits all forms of FGM/C was removed by the Council of Ministers from the Child Act Bill 2009. This decision followed a fatwa of the Islamic Jurisprudence Council, which called for a distinction to be made between the various forms of FGM/C and not to ban Type I which is known in Sudan by the *Sunna* type (Madani, 2010).

Legal Frameworks at State Levels: How did Existing Statistics Help

As Sudan is using the federal system, states are allowed to have their own legislations and formulate their own Child Acts. The first was in the State of South Kordofan in 2008 followed by Gadaref State in 2009, where both have ratified Child Acts with an article banning FGM/C. The process in most of the states included a group of legislators, government officials, researchers and NGOs. Most of them started with orientation meetings with key decision makers and legislators using existing statistics on the practice at national and state levels. These were complimented by religious writings of prominent Sudanese Religious Scholars who favour the abandonment of the practice. Extensive workshops and orientation sessions on the prevalence, status, reasons and consequences of FGM/C were then carried out for NGOs, advocacy groups and ministries officials to set the stage for the drafting of the law. One official in South Kordufan indicated that this was very essential to do so as to ensure that legal personnel drafting and reviewing the law understand fully the scope and magnitude of the practice in the state. They have made use of the SHHS of 2006 and their own states information to influence legislators to support and pass the Child Act. Child Act in Blue Nile, Kassala and River Nile states are pending ratification. Other states such as Red Sea and North Kordofan are still being reviewed with an article banning FGM/C, South Darfur has recently drafted a State Child Act including banning of FGM/C while in Khartoum State, the State Council for Child Welfare is working with the SMoH to draft RH Law that clearly bans FGM/C. In states where laws were passed, there is still the challenge of operationalizing these laws and translating them on ground.

Media campaigns also do exist at federal, state levels, and community level using different radio programmes with key informants and leaders messages, songs and role plays to encourage abandonment of the practice. These are meant to assist in advocacy campaigns by disseminating results of surveys in key daily newspapers, hosting officials in national TV channels to reflect on results of surveys and also to talk about the national Saleema campaign. This has resulted in public opinion building which has facilitated the work of many legislators and activists in the campaign. For instance, a recent review of different efforts done at the media level during the period 2000-2010 about FGM/C in Sudan was done by a media group supported by the UNFPA. The review booklet contained about 51 articles published at that time almost through all the national newspapers. The articles were written by different professional authors (males and females). Out of the 51 articles, 10 were about the legal status and the national laws criminalizing FGM/C in Sudan since 1946. Those articles also reflected the legal efforts and progress been achieved so far. In addition, another 10 articles were published based on statistical data from different national health surveys and studies conducted by the considered organizations. Those articles contained scientific figures and data to enlighten and educate the people about FGM/C. The remaining articles covered the religious and socio-cultural aspects of FGM/C in Sudan.

5. Entities & bodies that Advocate for Law Change and Lessons Learned

In Sudan, the entities and organizations involved in the national campaign against FGM/C include line ministries, professional bodies, academic and research institutions and NGOs. The results of their combined efforts have created the needed conducive environment for policy change and laws at states level, though they could not materialize the law at national level yet. The scope of their efforts can be summarized as follows:

- FMOH- RH Directorate – Chapter on FGM/C in RH Strategy
- Medical council – Statement against FGM/C
- FMOE, NCCW & UNICEF – Integration of FGM/C in school curricula and training of teachers
- National Population Council – inclusion of FGM/C in Population Policy in 2001 and the 2011 draft
- Ministry of Social Welfare – inclusion of FGM/C in the endorsed Women Empowerment Policy, 2009
- Non-governmental organizations (pioneers in the campaigns using different approaches of advocacy and community mobilization)
- FGM/C Networks of NGOs – part of the advocacy groups
- Media - newspapers mainly and few radio programs
- INGOs – support of awareness & community based projects
- Embassies – e.g. Japanese & Norwegian Embassies provided support of advocacy work

Advocacy Efforts:

Advocacy among policy makers and planners is an integral part of the National campaign. Several activities were carried out, and the outcomes of these efforts include;

- Medical council statement against FGM/C
- Sectoral policies outlawing FGM/C
- States committees within different Ministries e.g. Kordufan and Gadaref States
- National campaigns for 6th of February International Day on Zero Tolerance to FGM/C involving key people such as the First Lady of Sudan
- Meetings with policy makers and parliamentarians to sensitize them on the risks of the practice and its violation of girl's human rights.
- Advocacy for state laws outlawing FGM/C in effect

Lessons Learned

In many ways, brining an end to FGM/C requires changing community norms and societal attitudes that discriminates against women and subjugates their rights to those of men. Programmatic interventions must aim to promote the empowerment of women and girls through awareness raising campaigns and increasing their access

to education, as well as their access to and control of economic resources. Accelerating social change and creating the necessary preconditions will enable women to realize the full extent of their rights and may help them conclude that the practice of FGM/C can end. This requires more studies and data on views of men, and other key decision makers in the society such as religious leaders, midwives, legislators and others on their perception and attitude towards the practice. The information provided by the SHHS of 2010 on men views is a very important eye opener for advocacy work as well as for planners and it shows the impact of the heavy targeting of men via the campaign in the past five years. The access of media to information and statistics as well as the way they were disseminated have provided legitimacy and strength to work by advocacy groups particularly among NGOs. The analysis of why FGM/C is practiced among a given group or region is essential for the design of culturally appropriate, effective programmatic interventions.

5. Conclusion & Recommendations on the Way Forward: Engendering Data/Statistics.

FGM/C is no longer a cultural practice alone, removed from the scrutiny of international attention and human rights concerns. Rather, it has become a phenomenon that cannot be independently evaluated without looking at the social and economic injustice surrounding women and girls. Any approach that aims to end FGM/C must incorporate a holistic strategy that addresses the multitude of factors that perpetuate it. Evidence based planning for the national campaign is essential and pertinent to ensure the continuation of the decrease in prevalence and support by key stakeholders in the community. There are many challenges facing advocacy groups in their campaign, including pro FGM/C advocates with some political backing, religious backing and linking of the practice to Islam, and lack of coordinated efforts between the different sectors. Information sharing and monitoring of impact of campaign and the operationalization of laws in states are very important elements for the success of the campaign.

With regard to future research and studies, here are some recommendation based on the analysis above:

1. Changes in the practice of FGM/C do not only occur in reaction to the abandonment efforts only, but because culture and society are not static, and therefore research need to capture the dynamic changes within the social conventions and shifts in ideologies of the society.
2. Changes occurred in the design and implementation of FGM/C abandonment intervention where a shift in methods and methodology has been made to tackle the practice. Campaigns were based on community-based, comprehensive, behavior change interventions to address FGM/C in its broader context were not properly monitored or evaluated, so there is no systematic evidence on how effective they are with regard to behavior change.
3. Most research concerning FGM/C to date has described the prevalence of the practice, regional variation and touched upon reasons for continuation or support of the practice. There is a need for future statistics and data

to reflect how and why such results happen, to correlate with the socio-cultural and psychological context in which these decisions are made and how they are made.

4. Social convention and inclusion are powerful aspects in most of the Arab countries where FGM/C practice is high. They influence decisions on the practice, and may even make girls themselves desire to be cut, to conform to their peers pressure and for fear of being stigmatized or rejected by their community (UNICEF 2005). Studies on how FGM/C practice enhances social inclusion for girls are important to expose the means by which a positive messaging campaign like *Saleema* one can influence girls and empower them to challenge the practice.
5. FGM/C is an important part of girls' and women's cultural gender identity and may also bring a sense of pride, of coming of age and a feeling of community membership. Girls who undergo the procedure are provided with rewards, including celebrations, public recognition and gifts that make them request to be cut so they experience this special treatment. Studies and evidence are needed to study on how far families that have abandoned the practice are ensuring gender equality and empowerment of their daughters
6. Men are integral part of the decision making process and hence need to be interviewed in future surveys with all questions on FGM/C and not only by specific one or two questions as in the case of the SHHS of 2010.

References:

Abdel Magied, Ahmed (2002) overview and assessment of anti FGM efforts. in Sudan. Khartoum: Unicef Khartoum.

Almroth L, Bedri HA, Elmusharaf S, Satti A, Idris T, Hashim MS (2005a). Urogenital complications among girls with genital mutilation: A hospital based study in Khartoum. *African Journal of Reproductive Health*, 9:127–133.

Almroth L, Elmusharaf S, El Hadi N, Obeid A, El Sheikh MAA, Elfadil SM (2005b). Primary infertility after genital mutilation in girlhood in Sudan: a case−control study. *Lancet*, 366:385−391.UNICEF 2010 Legislative Reform To Support The Abandonment Of Female Genital Mutilation/Cutting

Elmusharaf S, Elhadi N, Almroth L. Reliability of self reported form of female genital mutilation and WHO classification: cross sectional study. BMJ, 2006; 333:124-7

Elmusharaf S, Elkhidir I, Hoffmann S, Almroth L. A case control study on the association between female genital mutilation and sexually transmitted infections in Sudan. BJOG, 2006; 113:469-74

Medani, Amin M. (2010) Criminal Law and Justice in Sudan. Accessed on March 2012. Available at: www.pclrs.org/Amin_Mekki_Medani_Paper.pdf

Safe Motherhood Survey (1999) Federal Ministry of Health, Central Bureau of Statistics & UNFPA. Sudan.

Sudan Demographic Health Survey (1989). Federal Ministry of Health & Central Bureau of Statistics. Sudan.

Sudan National Household Survey (2006). Federal Ministry of Health & UNFPA.

Sudan National Household Survey (2010). Federal Ministry of Health & UNFPA.

www.soatsudan.org (2006). Female Genital Mutilation in Sudan

UNFPA (2012). Promoting Gender Equality: Frequently Asked Questions About FGM/C. Accessed on March 2012. Available at: http://www.unfpa.org/gender/practices2.htm

UNICEF Innocenti Digest (2006). Changing a Harmful Social Convention: Female Genital Mutilation/Cutting. UNICEF

WHO (2012) Female Genital Mutilation. Accessed on March 2012. Available at: http://www.who.int/mediacentre/factsheets/fs241/en/index.html

WHO (2008) Eliminating female genital mutilation: an interagency statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO. Accessed on March 2012. Available at: http://whqlibdoc.who.int/publications/2008/9789241596442_eng.pdf

WHO Study Group on Female Genital Mutilation and Obstetric Outcome (2006). Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. *Lancet*, 367:1835−1841.