



Gift of the United States Government



Female Genital Mutilation- Practices Amongst the Refugee Population in Upper Nile State, South Sudan

Maria Vargas Simojoki

21-Apr-14

ABOUT THE DANISH REFUGEE COUNCIL (DRC)

The Danish Refugee Council (DRC) is a humanitarian, non-governmental, non-profit organisation founded in 1956 that works in more than 30 countries throughout the world.

DRC has been working with the Southern Sudanese refugees residing in Uganda since 1999. Upon the 2005 Comprehensive Peace Agreement between the Northern and Southern Sudan, DRC started operating in South Sudan with the overall objective of providing durable solutions for refugees, IDPs and returnees.

In Upper Nile State DRC implements a multi-sector response including: Camp management, shelter, Non Food Item (NFIs) distributions, community services, livelihoods and protection activities.

The production of FGM assessment was made possible by funding from the United States Government through the Bureau for Population, Refugees and Migration (BPRM).

The contents of this paper are the ideas and opinions of the author and do not necessarily represent the views of the organisation or the donor agency.

Acknowledgments

I would like to thank all the people and organisations involved during this assessment as without their help it would have been impossible to delve into such a sensitive topic such as Female Genital Mutilation (FGM).

In particular I would like to thank the extremely helpful MSF staff in Batil, who were supportive and provided insightful information.

The DRC teams provided support all around – from logistics to translation and I am extremely grateful for everyone’s flexibility, enduring support and good humour. The protection team of DRC provided excellent comments and guidance which helped shape this report.

The refugees of Maban County are extremely helpful and welcoming – and in discussing with different groups on FGM there was always a willingness to provide information and a very good disposition to discuss such sensitive topics. Special acknowledgement to the Youth leader Oler in Doro Camp, who volunteered his time for translation and organisation, and to all the Sheikhs and Umdas of both Doro and Batil camps for their infinite patience with my multiple questions throughout several months.

Finally, I would like to acknowledge that the production of this report was only possible through the financial assistance from the Bureau of Population, Refugees and Migration (BPRM).

Maria Vargas Simojoki

Maban County, Upper Nile

EXECUTIVE SUMMARY

Objectives of study

The general objective of this study focused on trying to gain information on female genital mutilation (FGM) amongst the refugee population living in Maban County, Upper Nile State. Emphasis was placed on trying to map what are the practises in the camps including differences between ethnic groups. At the same time the study looked into the perspective of a multiplicity of actors including youth, men, sheikhs, imams, women and traditional birth attendants to try and present as comprehensive a view on FGM as possible.

General findings

In general terms the assessment found that female genital mutilation (FGM) is being practised across all refugee camps in Maban County though various degrees of practices as well as the type of FGM performed.

In Doro Camp many groups mentioned a decline in FGM practice in their communities – a change that in most cases was initiated in Blue Nile through awareness campaigns from NGO’s and some medical practitioners. Some of the groups also diminished or even stopped their FGM practice after displacement to South Sudan as some awareness raising has also taken place in Doro Camp.

Nonetheless FGM is still practised in Doro Camp though the most severe form of FGM type 3 or infibulation has according to all beneficiaries ceased to be practised. Due to the awareness raising campaigns in Blue Nile populations are more aware of dangers of FGM and there is now a certain social pressures do not practice FGM. This has to lead to a more secretive practice of FGM. This makes it difficult to map the practises and target specific groups or provide services to those undergoing FGM.

The table below shows basic data on FGM in Doro Camp including current incidence of FGM:

COMMUNITY	Practiced FGM	Type	Age of FGM procedures Practitioner		Continued FGM practice
Sorghum	Yes	Type 3	< 3 years old	TBA ¹	No
Mayak	Yes	Type 3	< 5 years old	TBA	Potentially in secret
Baldugo	Yes	Type 3	<3 years old	TBA	No
Regarik	Yes	Type 1	N/A	TBA	Potentially in secret
Darfur	Yes	Type 1	N/A	TBA	No
Ingassana	Yes	Type 1	7 days old	TBA	Yes
Zariba	Yes	Type 1	< 5 years old	TBA	No
Balila Dawala	Yes	Type 1	< 2 months old	TBA	No
Yabus	Yes	Type 3	N/A	TBA	No

Respondents in Doro Camp also mentioned that in some communities FGM is no longer a pre-requisite for marriage and that communities discourage a continued practice of FGM. In many cases communities requested continued support to try and completely eradicate FGMA as they believe that the good work started in Blue Nile should be continued in Upper Nile.

In Batil Camp the practice of FGM is almost a given for all women and girls of the camp. All ethnic groups interviewed (of which the Ingassana are the majority) confirmed a continued practice of FGM. Most groups in Batil practice type 1 FGM though sources mentioned that they previously had practised type 3 FGM and had moved away from it due to serious complications during child delivery.

Respondents mentioned that in almost all cases the practice takes place within the first month after the child is born. FGM is a normal practice of daily life for the inhabitants of Batil Camp and most cited reasons such as health of the girls, prevention of diseases and infection from germs and traditional practice as the main

¹ TBA stands for Traditional Birth Attendant

reasons only few mentioned FGM as a Muslim practice. Interviews with religious leaders discredited religious connotations to FGM as they mentioned that only male circumcision was a mandatory practice of Islam.

Findings for Gendrassa Camp support data from Batil camp which is in line with the fact that these three camps have the same types of populations with a majority of Ingassana groups in all camps respondents in Gendrassa also mentioned a mixture of practice between type 3 and type 1 regardless of ethnic group. They mentioned that practices had also changed due to awareness raising in Blue Nile on the serious health consequences of type 3 FGM which they claimed they no longer practice.

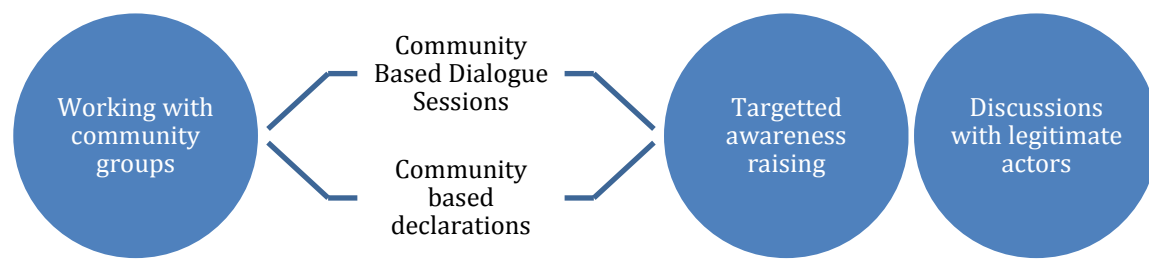
For both Batil and Gendrassa Camps the practise of FGM is deeply ingrained in social practice of all the groups.. Although some groups have received information on the negative consequences of FGM the majority consider FGM a normal practice of their ethnic group and believe it should be continued.

RECOMMENDATIONS

The findings point towards very diverse scenarios in the different camps in Doro stopping FGM is underway and though still practice has become more private. In Batil and Gendrassa Camps it is the opposite as there are a few that have stopped practising FGM while the majority consider the practice normal and of a very public nature. Thus the recommendations for the camps will be different to try and best target the actual situation.

DORO CAMP

For Doro Camp it is recommended to work with a phased approach that targets both the duty bearers and the rights holder on the one hand it is important to continue working with populations to disseminate information but on the other hand it is also important to obtain the buy in from authorities that can help push for definite change.



COMMUNITY BASE PUBLIC DISSEMINATION INFORMATION, AWARENESS & LEGITIMACY

The three main activities for Doro Camp are:

- 1) continue awareness raising with communities include duty bearers target messages accordingly and help communities also gain more detailed information
- 2) capitalise on existing groups to disseminate the information but also to allow for discussions in groups
- 3) community based dialogue sessions (started in step 2) expand to whole community and can result in community based declarations in which the whole community declares they will no longer practice FGM.

BATIL CAMP

As mentioned above the situation is different for Batil Camp and FGM is considered as a normal practice in the majority of the communities. The strategy for the camp should focus strongly on information dissemination, advocacy, outreach and finally also community discussions. For Batil Camp it is highly recommended that information dissemination is also done through health partners and that it also includes duty bearers given that as health perspectives might be the best starting point for later discussions.

Once information dissemination has been underway it is important to expand the awareness raising to the community level and work through community structures. Finally if enough awareness has been raised dialogues in communities can be supported these forums allowing for information exchange but also debates on the issue. The figure below illustrates the three main recommendations for Batil Camp:



If three main recommendations work well it is also recommended to expand the activities slightly and start an exchange between Doro Camp and Batil Camp especially regarding ethnic groups present in both camps, namely the Ingassana. As the population of Doro Camp seems better informed on the negative consequences of FGM sheikhs and other stakeholders could provide good perspectives to those of Batil Camp.

Finally the recommendations for Batil Camp are also applicable to Gendrassa Camp as the populations are similar and the understanding of FGM seems to be the same.

Contents

INTRODUCTION.....	7
FEMALE GENITAL MUTILATION – THE CASE OF SUDAN.....	8
METHODOLOGICAL AND ETHICAL CONSIDERATIONS	10
Data collection – asking sensitive questions	12
Consent.....	12
Challenges in data collection.....	12
Commitment to action-oriented research	13
THE REFUGEE CAMPS OF MABAN COUNTY – A BRIEF INTRODUCTION.....	13
FINDINGS	16
DORO CAMP	16
FGM - Who, what, when and where?	16
Re-infibulation in Doro	16
Has FGM become a secret practice in Doro?.....	17
Women’s understandings of FGM	18
The men’s perspective.....	18
Perspectives from Religious Leaders	19
Changing dynamics – will FGM continue to be practised amongst Doro populations?.....	20
BATIL CAMP.....	21
Who, what, when and where?	21
Why is FGM practised?.....	22
The men’s perspectives on FGM.....	23
Perspectives from Religious Leaders	24
What should happen with FGM? –Views of the respondents’	24
GENDRASSA CAMP.....	25
RECOMMENDATIONS FOR FUTURE PROGRAMMING.....	27
DORO CAMP	27
BATIL CAMP	29

INTRODUCTION

In April 2012 the Danish Refugee Council (DRC) started its emergency operation in Maban County, Upper Nile State, South Sudan. Programmes came directly as a response to the massive influx of refugees from Blue Nile State, Sudan, that started in November 2011.

As part of the DRC response protection, sexual, gender based violence (SGBV), prevention and awareness programmes were developed to target the refugee communities. During 2012 the SGBV staff conducted very thorough assessments on the general SGBV concerns for girls and women in Jammam, Doro and Batil Camps. These studies confirmed rumours that Female Genital Mutilation (FGM) was taking place in the refugee camps. The studies also offered some insight into the reasons for FGM but could not go further into details without jeopardising data collection on other Sexual and Gender Based Violence issues.

To try and address issues relating to FGM DRC commissioned this study to gain better understanding of the magnitude of the practice, as well as to provide recommendations on ways forward for targeted SGBV prevention programming.

The general objective of this study focused on trying to gain information on female genital mutilation (FGM) amongst the refugee population living in Maban County, Upper Nile State, as little to no information was available to base future interventions on. Moreover information available was often patchy and did not follow through all the camps, as FGM questions were deemed as sensitive and in many instances the information was anecdotal. Therefore the main objective of the study was to look into FGM practices within the refugee populations in Maban County, specific objectives of the study are listed below:

- 1) Provide an overview of FGM practices in Sudan and a desk review of pertinent materials.
- 2) Extensively map FGM practices in Doro and Batil Camps.
- 3) Provide insights into FGM practices in Gendrassa and Kaya Camps, including types of FGM and cultural practices associated to FGM
- 4) Provide an understanding of how pervasive is FGM amongst the refugee population in Maban County
- 5) Engage different stakeholders in both camps to try and understand differences in perspectives between men, women, youth and traditional leaders.

The assessment begins by presenting a condensed version of the different types of FGM and some issues relating to FGM practices in general. It moves to presenting the general situation regarding FGM in Sudan – previous practices, as well as how those practices have changed through governmentally supported campaigns against FGM. The introductory section also delves into methodological considerations regarding the data collection of this assessment and finally presents an overview of the refugee camps in Maban County.

The subsequent section presents findings of the assessment per camp, trying to highlight some of the differences in practices between the diverse ethnic groups spread over the four refugee camps, as well as presenting the views of diverse refugee population groups and secondary data gathered from key informant interviews with actors in the camps.

The final section presents general recommendations for actors operating in Maban County on how to work towards stopping the practice of FGM.

The people who practice Female Genital Cutting [FGM] are honourable, upright, moral people who love their children and want the best for them. That is why they practice FGC [FGM] and that is why they will decide to stop practising it once a safe way of stopping is found...” (Mackie, 2000: 280)

FEMALE GENITAL MUTILATION – THE CASE OF SUDAN

Practices related to female genital mutilation (FGM) are traditional practices through which women’s genitalia are maimed or mutilated². UNFPA estimates that between 100 and 140 million women already submitted to some type of FGM and statistics show that prevalence of FGM is mainly restricted to 28 African and Asian nations (UNFPA, 2008). The actual type of FGM varies substantially from country to country and in between ethnic groups of the same area. WHO has classified FGM into four types which are listed below³ (WHO, February 2013):

TYPE 1	TYPE 2	TYPE 3	TYPE 4
Excision of the prepuce, with or without excision of part or all the clitoris (sometimes called a clitoridectomy)	Excision of the clitoris, with partial or total excision of the labia minora	Excision of part or all of the external genitalia, with stitching/narrowing of the vaginal opening (infibulation)	Unclassified: includes pricking, piercing, or incising of the clitoris and/or labia.
In Sudanese Arabic: Sunna	In Sudanese Arabic: Sunna	In Sudanese Arabic: Pharaon/ Pharaonic	

The practice of FGM has been discouraged in many countries and there are several nations that have passed legislations prohibiting the practice of FGM in Sudan a law abolishing FGM was passed during colonial rule in 1946 and subsequently the Government of Sudan passed a partial law (not including all states) in 2008/2009. Nevertheless FGM is still practised in many communities as it is traditional practice deemed as necessary for girls to become women. Reasons for the practice of FGM range from purity, making women ready for marriage, religious reasons and even health reasons as communities quote that female genital parts can be infected if not mutilated.

FGM practices in Sudan vary depending on the ethnic group in question. In general terms data shows that there is a slow decline in the overall practice of FGM in Sudan, as in 1977 it was an approximate of 96% of girls that underwent FGM while data from 1989/90 shows that it has decreased to 89%. Moreover data shows that there has been a shift from practising the most severe version pharaonic or infibulation (type 3) to a milder form better known as ‘sunna’ (type 1) (Republic of Sudan 1990; 2006). However a newly published statistical report from UNICEF warns that for countries such as Sudan the rate of decrease has been minimal and that figures of 89% prevalence continue to be valid (UNICEF, July 2013).

Additional data from the Sudan Health Survey from 1990 shows that FGM can be practised on girls as young as a few days old to a maximum of 11 years old on average the survey points to an age between 6 to 8 years old when FGM is practised. Moreover the survey and subsequent health surveys (2006) show that there is little statistical difference between urban and rural environments when it comes to the practice of FGM (Republic of Sudan, 1990; 2006; UNICEF, July 2013) though some research points towards the type of FGM being

² Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (WHO, 2013)

³ For the purpose of this study the WHO types will be referenced to as much as possible, however traditional Sudanese Arabic terms might also be used (Sunna for types 1 and 2 an pharaonic for type 3) as these are the terms used during the interviews and the ones known by the respondents.

different in urban populations 'sunna' is more common while in rural populations infibulation is more common (Republic of Sudan, 1990).

In regards to other socio-economic factors that could affect the prevalence of FGM data from Sudan shows that there is little difference between the levels of education of respondents and their inclination to practice FGM except when respondents have achieved a university degree. However what is of interest is that girls from poorer households are more willing to support the practice of FGM (68% in favour) versus more wealthy girls (only 21% in favour) (UNICEF, July 2013).

For the purposes of this study the population in question is all from the state of Blue Nile in Sudan. In relation to the specific state data from the 2006 Sudan Health Survey shows that 58.2% of women in Blue Nile have undergone circumcision and 52.2% intended to circumcise their daughters. In general terms approximately half of the population agrees to the practice of FGM (Republic of Sudan, 2006) which is quite consistent with the fact that approximately 47% of women in the whole of Sudan agree with the practice of FGM and 55% of mothers willingly subject their daughter to FGM (UNICEF, July 2013).

Multiple studies conducted in Sudan on FGM issues also point towards the practice of re infibulation which means women are sewn up after delivery of children and in some cases 're-tightened' (better known in Arabic as El-Adel). This practice however only pertains to women that already have been infibulated and not to those that have been subjected to clitoridectomy (type 1) and or excision of the clitoris (type 2)

The prevalence of FGM in general information points towards a very strong traditional practice perpetuated by the women of the community. Women are motivated to perpetuate FGM on their daughters and female relatives as FGM has strongly been associated with the 'marriageability' of a young woman. .

Research into issues related to harmful practices including FGM shows that practices such as FGM might have spread as groups that did not practice FGM wanted their daughters to marry into better families or groups that practice FGM. People started mutilating their daughters in what they believed was their best interest as marrying those more powerful or rich will ensure her and the family an improved quality of life. Additional concerns are for example purity or control over the wife and becomes what is describes as: *"In present-day Egypt and the Sudan, the hypothesized source of origin of FGC, not only is it a matter of marriageability, but it is also associated with the virtue of the woman and the honor of her family within a comprehensive and exaggerated modesty code.."* (Mackie, 2000:269)

Following what is described above FGM is also is now considered, *"it is now widely acknowledged that [FGM/C] functions as a self-enforcing social convention or social norm..."* (UNICEF, 2013: 15), which has specific consequences for how to work with FGM and the eradication of FGM. Reasons for why FGM is now being considered a social norm are described in the criteria below:

- 1) *Individuals are aware of the rule of behavior regarding the cutting of girls and know it applies to them*
- 2) *Individuals conform to this rule because: a) they expect a sufficiently large segment of their social group will enforce the practice and (b) they believe that a sufficiently large segment of their social group thinks that they ought to follow the practice. There will be negative consequences if they do not comply.* (UNICEF, July 2013: 14-15).

Basically the idea of FGM as a social norm entails that FGM is an individual practice only validated when perceived as collective . Consequently if you believe in FGM and think your neighbors or community members believe in FGM the practice is legitimized. As such it becomes engrained in social standards.

As was mentioned above, the importance of classifying FGM as a social norm generates implications on the response mechanisms that can be used.

The fact remains that FGM is considered a harmful traditional practice as it subjects women to unnecessary mutilation that has negative consequences including but not limited to higher infection rate, urine retention, potential infertility and psychological trauma (Almroth, 2005; Bergreen, 2005). Additionally, but not least

important, FGM is a violation of women's human rights⁴ and should also be considered through a rights' lens that focuses on the practice and the eradication of the practice on the basis of it being considered violence against women. Efforts to eradicate FGM in many countries have focused on women's rights to physical integrity⁵ such as the UNICEF campaign in Sudan *Saleema*" that focuses on keeping girls complete such as God made them (UNICEF, July 2013).

METHODOLOGICAL AND ETHICAL CONSIDERATIONS

This study is based on an extensive desk review of academic materials as well as field study inputs. Data collection consisted of two main sources: interviews with humanitarian partners involved in SGBV, health, child protection and camp management through focus group discussions with refugee men, women, girls and boys in both Doro and Batil Camps.

Interviews

Semi-structures interviews were conducted with humanitarian actors with relevant knowledge of the subject matter. All health providers were consulted in both camps and an effort was made to also liaise with child protection partners in both camps. Interview duration varied as depended on the knowledge of the interviewee and emphasis was placed on letting people talk about their experiences and knowledge instead of strict closed ended questions.

Focus Group Discussions

Focus group discussions were conducted in all four camps (see table below). All focus group discussions with refugees required translation as in most cases just from English into Arabic but for some groups (mainly women) translation was needed from English-Arabic-Ingassana.

All focus group discussions were conducted in coordination and with assistance of the DRC protection, SGBV and camp management teams. As is noticeable from below not exactly the same groups were interviewed in both camps as groups for the discussions had to be easy to mobilise and willing to discuss the issues.

For purposes of this study Uduk communities (in Doro Camp) were not taken into consideration as it was already clear beforehand that they do not practice FGM (DRC Doro Camp, 2012). Therefore only the remaining communities within Doro were interviewed or consulted on FGM issues. The communities are: Mayak, Sorghum, Baldugo, Ingassana, Regarik, and Jum Jum. The community of Nuban refugees was not consulted due to time constraints.

Using different terminology – cutting vs. mutilation and issues of translation

The practice of cutting female genitalia has passed through different terms throughout times first it started off as circumcision but this was abandoned as it did not correctly refer to the fact that a healthy part is being cut, which is how the term mutilation came into use. However many researchers and policy makers argued that mutilation is a very harsh term that introduces an element of shaming people that do not know any better (UNICEF, July 2013). Since then the term female genital cutting was introduced to provide a term that took into account that traditional practices take a long time to change and should not always be judged with a western eye. For the purposes of this study all the interviews with respondents were conducted in Arabic where the term "*Tahuur*" literally means circumcision (for both boys and girls). Effectively this means that when contacting respondents the mildest version was utilised as it is the one that they (and the translators) are familiar with. For purposes of the report (which is written in English) the term used will be FGM as it is considered the best to address this extreme rights violation.

⁴ FGM was re-conceptualized from just practice affecting health to a human rights violation (violence affecting women) in the 1993 World Conference on Human Rights in Vienna.

⁵ Based on the Universal Declaration of Human Rights – Article 25.

Focus Groups Discussions per camp (Doro and Batil Camps):

DORO CAMP	PARTICIPANTS	BATIL CAMP	PARTICIPANTS
Selected women's group	32	Selected women's group	36
Selected women's group	25	Selected women's group	18
Selected women's group	17	Selected women's group	15
Young men	28	Young men	9
Men (selected sheikhs ⁶)	30	Men	9
Young women	19	Young women	0 ⁷
Traditional Birth Attendants	12	Traditional Birth Attendants	15
Religious leaders	5	Religious leaders	12

Groups for Gendrassa Camp were chosen based on the initial idea that both camps already had women's committees to aid mobilisation. The idea to try and also interview girls and boys (which was finally only possible in Gendrassa) was to ascertain knowledge outside communities of practice and power. In many cases adolescents or pre-adolescents provide good insight into how knowledge is accessed in a community, what they know or do not know points out how much information is shared with different age groups and also how they might react to certain issues like for example FGM.

At the time of writing, the Gendrassa and Kaya camps did not have access to a SGBV humanitarian partner and following best practices it was decided to keep data collection in these camps to a minimum as collecting data without being able to provide follow up interventions can be counterproductive (WHO, 2007). However, to try and provide a comprehensive view on FGM three focus groups were conducted in Gendrassa. Focus group discussions were attempted in Kaya but unfortunately due to several limitations including the month of Ramadan it was not actually possible to conduct any data collection in Kaya.

Trying to ascertain the extent of a practice such as FGM is always a difficult task as responses are conditioned to social norms, interactions and understandings. Though it will never be possible to fully claim that we "know" the complete extent of the practice of FGM in the camps this assessment aims at providing as much information as possible and importance was paid in design phases to try and include as many ethnic groups and to obtain information from different types of respondents including men, youth and not just women to provide varied information as possible to allow for basic triangulation of data.

Focus Group Discussions for Gendrassa Camp:

GENDRASSA CAMP	PARTICIPANTS
Selected women's group	20
Girls (adolescents)	13
Boys (adolescents)	15

The main questions asked at focus group discussions placed emphasis on:

- Practices of FGM within the community (yes/no) with follow up questions of when, how and who performed the mutilation
- Multiplicity of practices related to different ethnic groups in camps (with mixed groups)
- Reasons for FGM

⁶ Sheikhs that had previously voiced concern about FGM in their communities

⁷ Focus group discussion could not be conducted as respondents failed to attend meeting appointments three times.

- Decision making related to FGM including the relationship/decision making power of men related to FGM
- Effects of FGM and services available that women could access
- Perceptions of FGM and what do respondents think about FGM?

All focus group discussions also had a question/answer session at the end where interviewees could ask questions from the facilitator. Additionally the facilitator remained available after the FGD ended in case interviewees wanted to elaborate on issues in a private manner.

Data collection – asking sensitive questions

Although some populations in the refugee camps of Maban have received information and awareness raising about FGM it remains a controversial topic that could potentially harm the relationship of DRC with the communities. In order to try and gain trust the main methodological strategy was to first start data collection with groups already under the DRC umbrella such as volunteers, women’s committee and youth committee members. In other instances assistance was requested of partners with technical specialization, for example help was requested of child protection actors for interviews with adolescents girls and boys. In Gendrassa INTERSOS assisted with mobilisation of girls and boys as well as participated in the focus group discussions. ACTED was very helpful in mobilising women in Gendrassa and Kaya camps.

Due to the nature of the subject at hand special care was put trying to make respondents comfortable with the interviewer, as mentioned above with several of the groups that participated in this study the interviewer visited the groups beforehand to try and establish some rapport with the individuals. Additional focus group discussions were conducted using resource people from the first tier interviews, thus helping facilitate contact with community members that have no direct weekly or daily contact with DRC.

Finally, due to the nature of the refugee camps based on traditional structures the study was first presented to the sheikhs and umdas of the camps as a courtesy and to gain their support.

Consent

Issues of written consent always arise when dealing with populations that are not accustomed to written consent (traditionally relying on verbal consent), as is the case of the refugee camps in Maban County. Respondents often feel suspicious of signing papers they cannot read and this mistrust might affect the flow of the interview or focus group discussion (Almroth, 2005; WHO, 2007). Due to this it was decided to instead elicit verbal consent from respondents. In all cases respondents were told about the study objectives and were informed of the confidentiality procedures.

Challenges in data collection

The rainy season in South Sudan is a force to be reckoned with and can derail even the best set plans. During the time of the study torrential rains interrupted focus group discussions and interviews. As the refugee camps have few communal shelters the fact that data collection was undertaken during rainy season was a challenge as focus group discussions under trees had to be rescheduled according to the weather situation

Another challenge was that the month of Ramadan coincided with the data collection (9th of July until 8th of August), which combined with the rains made it difficult to access beneficiaries as people often would be absent from their homes or too tired to participate.

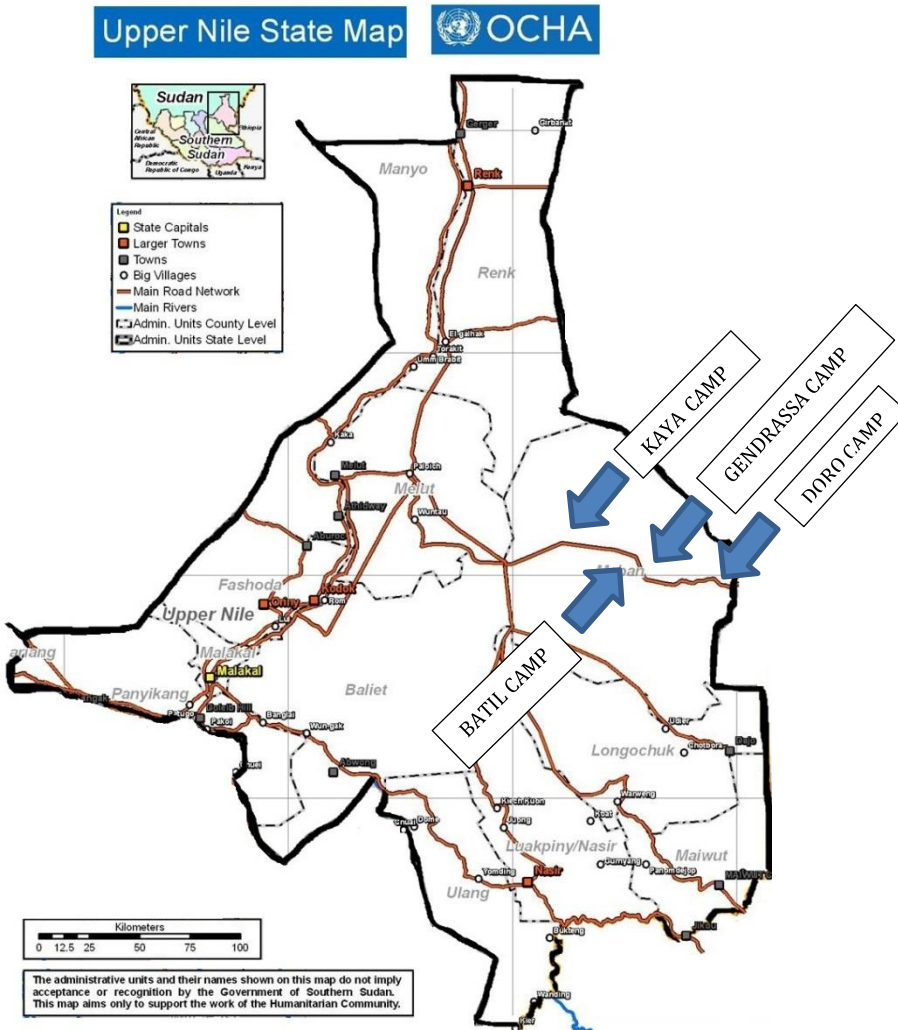
It is also important to mention how certain groups are very challenging to both mobilise and discuss with. Particularly some of the women have never been exposed to a situation where their opinions were asked and as such it also means many were shy to participate, but also found it difficult to understand what was required of them in a focus group discussion. Many women are also not used to voicing their opinion and this makes it difficult for them to participate in discussions.

Commitment to action-oriented research

During the data collection respondents were informed that all data collected would provide the basis for future programming in the subject of FGM. Trying to keep a commitment to good practices of research recommendations were presented (prior to completion of report) to all parties involved including one session in Doro camp, one session in Batil camp and one session for international humanitarian partners all the sessions were held mid-August. The idea of the sessions was to be able to present findings and recommendations to provide respondents the opportunities to comment on this to validate them so to say.

Additionally, when conducting research especially into fields like FGM there is a lot of misinformation, rumours or hearsay respondents often utilised the time after the focus group discussion to ask the facilitator questions related to FGM. In several occasions follow up activities were also scheduled for DRC SGBV Officers to provide awareness raising on FGM or for further discussions to be scheduled.

THE REFUGEE CAMPS OF MABAN COUNTY - A BRIEF INTRODUCTION



Conflict between the populations of Blue Nile State and the Sudan Government has historically been linked to general conflict between the Government of Sudan and southern armed groups; however in late

November 2011 the conflict escalated and prompted the mass displacement of several communities into Upper Nile State and South Sudan. Communities closer to the urban centres Damazin and Kurmuk fled into South Sudan and settled into what became Doro Camp, while Ingassana communities entered mainly through El Fuj border area and were settled into three camps mainly Batil, Gendrassa and Kaya camps.

The refugee camps of Maban County host approximately 117, 832 individuals (UNHCR data) of several different ethnic groups, and as such practices within the camps will differ substantially.

Doro Camp – diversity of practices

Doro camp hosts the largest amount of ethnic groups of all camps in Maban County. The camp is approximately divided into a 50-50 split between Uduk communities, who are Christian, and other smaller ethnic groups, who are mainly Muslim. The camp is arranged by ethnic composition, and all areas of the camp mirror the original communities in Blue Nile State. Most residents in Doro camp arrived late 2011/early 2012 though in June 2012 Ingassana groups were relocated to Doro camp to decongest the no-longer existing Jammam camp. In general population groups are mixed between previous inhabitants of urban and rural areas, and some of the refugees of Doro Camp are the best educated amongst the general refugee population.

Batil Camp – homogenous groups

The population of Batil camp is primarily Ingassana, though there are some minority groups of Magaya and Jum Jum tribes also in the camp. Back in Blue Nile State the Ingassana now inhabiting Batil were mainly rural populations who keep animals and did light agricultural production. The majority of Batil's inhabitants arrived in May 2012, though some were also relocated from Jammam camp in July/August 2012. All inhabitants of Batil camp are Muslims and from previous DRC assessments there was an indication of high FGM prevalence within the camp (DRC Batil Camp 2012).

In general terms the population of Batil camp has maintained their traditional structures from Blue Nile state as well as their traditional practices. Though a completely Muslim population the Ingassana people have been known to have strong connections to their spiritual and traditional practices especially the use of magic and protective charms and their socio-cultural links continue to be strong even in the refugee setting (DRC, January 2013: 10). It is also important to note that the population of Batil Camp is largely an uneducated population that has had little exposure to services including health, or awareness raising campaigns.

Magaya and Jum Jum communities are minorities within the camps but especially for the Magaya they have normally cohabitated with the Ingassana even in Blue Nile and follow similar practices. Though some issues have arisen between the communities they remain closely linked to each other. The Jum Jum though different from the other two groups are Muslims and have managed to integrate with the Ingassana and the Magaya in Batil Camp.

Brief outlines of Kaya and Gendrassa Camps

Kaya and Gendrassa camps have similar characteristics to Batil Camp as they host the same ethnic groups the majority is Ingassana with smaller minorities of Jum Jum and Magaya populations though come from different areas in the Ingassana Mountains. Initially the populations of Gendrassa and Kaya lived together in the now-closed Jammam camp but due to the camp being a severely flood prone area and there being difficulties to provide drinking water the populations were moved to more suitable locations. People inhabiting severe flood prone areas moved first to what is now Gendrassa camp while those that had better conditions were moved at a later stage to Kaya camp.

Gendrassa camp was opened in July 2012 in order to respond to alleviate the pressure from Jammam camp. Geographically the camp is very close to Batil Camp at the closest point the camps are no further than 2 kilometres from each other and intermarriages occur between the population of Batil camp and Gendrassa camp.

Kaya camp is the newest camp of the four refugee camps in Maban County as it was started in early 2013 to finalise the move of people from the flood prone area of Jammam to a more suitable location. The Ingassana

populations of Kaya and Gendrassa camps seem to be better educated to those of Batil Camp – there are more people (including women) that speak Arabic and not just vernacular languages and many were urban dwellers that had access to basic services including education back in Blue Nile.

FINDINGS

In this section findings from the interviews and data collection are presented. Due to the diverse nature of the questions asked trying to ascertain specific issues as well as perceptions. The following section has been divided into sub-sections to facilitate understanding the results. In general the results are presented by camps as the situation is quite different from camp to camp, and are presented mainly following a line that first looks at what actually happens, then at reasons behind FGM, men’s perspectives and knowledge on FGM and finally the outlook of respondents on FGM related issues in each camp. For Gendrassa and Kaya as reduced numbers of interviews were conducted and the populations are very similar the results are lumped in one section.

DORO CAMP

FGM - Who, what, when and where?

From the 2012 DRC SGBV Rapid assessment it is clear that FGM is practiced within Doro camp. According to the rapid assessment “62% of interviewed individuals and 56% of key informants belonging to a Muslim community admitted that FGM is a traditional practice present in their community.” (DRC Doro Camp, 2012: 13)

In general FGM is only practised within the Muslim populations in Doro Camp – and even then practices, ages and types vary between the different ethnic groups. The table below presents a brief overview of groups now residing in Doro Camp that traditionally have practiced FGM, the type of FGM they used to practice, the age the practitioner and whether FGM continues to be practised in the community in question:

COMMUNITY	Practiced FGM	Type	Age	Practitioner	Continued FGM practice
Sorghum	Yes	Type 3	< 3 years old	TBA ⁸	No
Mayak	Yes	Type 3	< 5 years old	TBA	Potentially in secret
Baldugo	Yes	Type 3	<3 years old	TBA	No
Regarik	Yes	Type 1	N/A	TBA	Potentially in secret
Darfur	Yes	Type 1	N/A	TBA	No
Ingassana	Yes	Type 1	7 days old	TBA	Yes
Zariba	Yes	Type 1	< 5 years old	TBA	No
Balila Dawala	Yes	Type 1	< 2 months old	TBA	No
Yabus	Yes	Type 3	N/A	TBA	No

Moreover respondents in Doro camp mentioned that most groups practised or had practised type 1 (sunna) FGM, while it was only three of the ethnic groups mainly the Baldugo, Yabus and Maya that mentioned that they used to practice type 3 or infibulation (pharaonic). In all three communities FGM had stopped at the time of this assessment. In the case of the Baldugo FGM had started declining while they were in Blue Nile as doctors close to the community started discouraging the practice due to the severity of complications derived from type 3 FGM especially during child delivery. For the Yabus and the Mayak communities they stopped practising FGM when they reached Doro Camp as they received awareness raising on the subject mainly from health professionals.

Re-infibulation in Doro

One important aspect to note though is that normally when women have undergone Type 3 FGM there is a continued violation through the practice of re-infibulation of women after delivery of children. Respondents’ views on this subject were mixed. In general terms respondents mentioned that re-infibulation

⁸ TBA stands for Traditional Birth Attendant

takes place after the delivery. However when asked whether women from their communities deliver in the hospital the respondents mentioned that the majority delivered in the hospitals. Re-infibulation would not be possible in the hospital as it is not performed by the health care professionals that attend the women. This would indicate that re-infibulation has to happen when the women return home after delivery. This is however unlikely, because the usual practitioners (the TBA's) mentioned that they no longer practice re-infibulation at home. It is plausible topics are not normally discussed openly other women or men might not be aware of this.

Apart from the three communities listed above there are isolated cases of women that have undergone type 3 FGM given that they come from ethnic groups more associated to what respondents call "Arabs" (northern Sudanese ethnic groups) in which type 3 FGM is prevalent. These women have often intermarried into ethnic groups from Blue Nile. Thus, it is not likely they would continue to practise type 3 FGM because this is not normally practised by their husband's ethnic groups.

Has FGM become a secret practice in Doro?

"As I child I went through pharaonic FGM (type 3). When I had to deliver my first child I could not reach the hospital. I found a TBA. The TBA was not able to deliver the child as she had never been in contact with an infibulated woman and did not have the necessary training to assist the woman. The TBA's that know how to deal with this are no longer here so we will not practice infibulation anymore. (FGD with women).

Respondents in Doro mentioned that the practice of FGM even in Muslim communities was declining though some still practised FGM. Emphasis was placed on the fact that community practices had been changing even before they became refugees as prior to displacement some communities had stopped practising FGM being aware of the negative consequences of this traditional practice. Respondents also confirmed the data presented in the Sudan Health Survey (1989/90 and 2006) mentioned that before infibulation had been quite common but in the last 10 years had become less and less practised and 'sunna' or clitoridectomy was instead becoming the norm.

In general respondents mentioned how FGM had now become a hidden practice within communities that in many cases the community members would not be aware of which family was practising FGM as it was done secretly. Only cases where the procedure went wrong were known to respondents because the girls had to be taken to the hospital. Throughout the different focus group discussions it became apparent that though many had received awareness raising in Blue Nile and had tried to stop the practice of FGM individual parents would still subject their daughters to FGM. Respondents mentioned that the parents were aware of the issues and thus they chose to do it secretly to avoid confrontations with other community members or being shamed in public. It is uncertain though why some parents would still chose to continue the practice even secretly.

A brief overview of compiled responses as to whether FGM is still being practised in the respective communities note that responses from men and women of the same communities are often contradictory and go to reinforce the aforementioned that not only is it extremely difficult to pinpoint the actual incidence of FGM in communities but that views on practices are so diverse that in many cases even members of communities might not be aware of what is taking place.

COMMUNITY	Practiced FGM	MEN	WOMEN
Sorghum	Yes	No	In decline/Stopped when in Doro
Mayak	Yes	No	In decline or done secretly
Baldugo	Yes	Yes	In decline – stopped 1 year ago
Regarik	Yes	In decline	In decline or done secretly
Darfur	Yes	Yes	No/ In decline
Ingassana	Yes	Yes – but aware it should stop	Yes
Zariba	Yes	N/A	In decline
Balila Dawala	Yes	N/A	Stopped when in Doro
Yabus	Yes	N/A	Stopped when in Doro

Women's understandings of FGM

Reasons for the practice of FGM mainly revolved around either health issues or issues of traditional practice. When asked whether religion was ever quoted as a reason for FGM women mentioned that FGM was not a religious practice and was not a prescription of Islam, however the women stating this were mainly those that also mentioned FGM had stopped when they came to Doro or was no longer practised.

For those women that mentioned that FGM was still predominant in their communities' reasons for FGM varied and did include religious reasons including that: *"women that had not been through FGM could not pray"*⁹. It is also important to note that women also mentioned that FGM was a necessary for marriage and no girl without FGM could get married, except in the Baldugo community where the eradication of FGM seems to have been so inclusive that the women stated that men would marry women without FGM.

"Stopping FGM is not up to them [women] but it is up to the men and the sheikhs. That if the sheikh can go around and convince others then it might stop and she would be happy to see this practice stop." (FGD with young women)

When directly asked their perspective on FGM women were quite reticent to voice their views, even for those that mentioned that it was no longer practised in their communities. In this aspect of the discussion many mentioned health reasons for stopping FGM include complicated deliveries, that FGM was not really prescribed by Islam and as such should not be practised. During discussions it became apparent that many women did not feel confident to voice their opinions except for some exceptional cases.

Particularly, women of Baldugo community all expressed happiness at having stopped the practice of FGM. The women mentioned that they felt relieved that it was not continued and that they were happy their daughters would not go through it. When asked about the opinions of their husbands on the matter one respondent mentioned: *"men were complaining about it because some of them liked women that went through circumcision [FGM], but we told them about the health issues with delivery and asked them whether they wanted to have their children suffer like that..."*¹⁰

The men's perspective

Practices such as FGM are mainly confined to the domain of the women in all the populations consulted. Men mentioned that they were aware that FGM was taking place and they would normally be asked to arrange for the items the TBA's needed for the FGM to take place, as well as arrange supplies for celebrations after FGM had been practised, but that that was the extent of their involvement with FGM on a domestic level.

In general terms men did not know the types of FGM practised in their communities, except in some cases where they mentioned that previously: *"they had practised the bad type and now they practised the good type"*¹¹, when questioned further on this it became apparent that previously infibulation was being practised while afterwards type 1 or 2 became the norm. In discussions with youth it became even more apparent that their knowledge is sparse and they rarely have contact with FGM issues. Of note is the fact that information on issues such as FGM seems to be of the domain of the married as the married youth were able to answer more questions than those that were still single and seemed to be kept out of the information sharing¹². Regarding the reasons for FGM there was a lot of emphasis placed on the fact that FGM was a Muslim practice that had been passed on to them ever since their communities had become Muslims. One man mentioned that he was told that before no FGM had been practised in his community but that after they had converted to Islam they had started practising it. Other reasons given were health reasons though none of

⁹ Focus group discussion with young women in Doro Camp, 29th of July 2013

¹⁰ Focus group discussion with women in Doro Camp, 1st of August 2013.

¹¹ Focus group discussion with sheikhs in Doro Camp, 19th of July 2013.

¹² Focus group discussion with young men in Doro Camp, 24th of July 2013.

the respondents could mention exactly what sort of health issues were meant to be avoided through FGM. None mentioned sexual pleasure as a reason.

In terms of exposure to previous awareness raising on FGM issues many of the sheikhs interviewed had been exposed to awareness raising back in Blue Nile which corroborates what some of the women had stated about campaigns that had helped curb the incidence of FGM in their communities. In discussions they were able to mention serious health effects on women that had undergone FGM mainly in relation to complicated or obstructed deliveries as well as issues with passing of menstruation blood and urine. The sheikhs that had been exposed to ideas of FGM as a harmful practice also mentioned that they would be very keen to be able to continue working towards stopping FGM in the refugee setting. This information was however not passed on to the young men, as when interviewed they had never heard of consequences of FGM or have had awareness raising.

“Back in Damazin, I knew two girls that had not undergone FGM – when they grew up they were ostracized, they were not able to marry and that led them to feel inadequate and depressed (FGD with sheikhs).

However when asked about whether women that had not been through FGM could get married both sheikhs and young men mentioned this was highly unlikely. They seemed open to working with communities on stopping FGM but they also admitted that in many of their communities FGM was a pre-requisite for marriage and that if the girl had not gone through FGM marriage would not take place.

In terms of decision-making all men, sheikhs, older men and youth mentioned the father as the key decision maker in the FGM process. Through follow up questions it was ascertained that the decision is a joint one between father and mother though they did place emphasis on the father’s role in the decision.

Perspectives on continuation of FGM were diverse for some of the sheikhs (particularly those that had been through some awareness raising) there was a clear notion that FGM should be stopped and they requested assistance in continuing to work against FGM. Nevertheless this was not the case for other men including sheikhs that had not been through awareness raising on the subject. Many of the men requested further information on health effects of FGM but yet the issue of marriage for girls was more pressing than potential health issues and the vast majority agreed it should continue.

Perspectives from Religious Leaders

On an interesting note, religious leaders consulted in Doro Camp all mentioned that FGM is not a practice that should be considered Muslim. Therefore it should not be endorsed. One imam however, acknowledged the perceived association between FGM and Islam and explained three factors for why FGM is sometimes considered a religious prescription:

- 1) *They have been told that FGM started in Egypt and became an edict of the king of Egypt. Otherwise known as the Pharaoh which is where the name in Arabic for Type 3 FGM comes from. People at that time obeyed the prescription of their king and started practising FGM (Type 3 regularly). The practice spread to other groups.*
- 2) *In the hadith the prophet Mohammed said to have encountered FGM being practised in villages in the Arabian Peninsula. He wanted them to stop and mentioned that it is better to just cut a small piece (type 1) than to do the full closure (type 3). Since this dialogue appears in one of the stories of the prophet it can easily be misinterpreted as being written in the Quran*
- 3) *FGM is normally associated to religion as it also has gained connotations regarding purity and cleanliness. In general Islam has a vast tradition regarding hygiene and cleanliness particularly many prescriptions as to how to become clean enough so you can pray. Somehow the two FGM and general hygienic prescriptions in Islam have mixed and FGM is associated to practices that have no relation to issues with cutting.¹³*

¹³ Focus group discussion with Imams in Doro Camp, 5th of August 2013

Imams also mentioned that once they had received information from doctors in Blue Nile that FGM was dangerous to women, especially during child delivery, they agreed to stop the practice as after all it is not dictated by the Quran, and why should they purposely harm women?

Changing dynamics - will FGM continue to be practised amongst Doro populations?

As can be seen from the findings, the practice of FGM in Doro is already in a state of flux. It is apparent that some groups have already started to move away from FGM and that in some communities it is now done as a 'hidden' thing instead of as the norm. Nevertheless FGM continues to be practised in Doro camp and in some communities it is still considered a norm for all women.

Differences in ethnicities in Doro camp as well as differences in levels of education and levels of awareness regarding issues relating to FGM would point towards a unique opportunity to try and completely eradicate FGM from all sections (ethnic groups) of the camp. In having groups that have similar backgrounds Muslims coming from rural areas of Blue Nile but that have diverging practices it is also possible to envision that if groups mixed and discussed these issues there could be a possibility for change.

However towards the end of the research period one young Baldugo respondent mentioned that recently she had heard 'talk' that maybe also the Baldugo would eradicate FGM as the mention of this was of interest according to older respondents the Baldugo have already stopped FGM (they mentioned over a year ago), which also indicates the lack of information dissemination amongst different age groups and people in the communities. Precisely this lack of information sharing with youth and with men also makes it difficult to fully eradicate practices as it is then easy to continue practices in secret.

"FGM was stopped when we were still in Blue Nile, yet we sometimes hear that people have continued the practice in secret even here." (FGD with women)

In light of conflicting information men, women and youth (both young men and young women) not sharing the same information about FGM practices within their communities it is difficult to ascertain the actual extent of FGM.

Findings for Doro Camp have shown that there are multiplicities of practices in the camp varying on the ethnic groups from communities that continue to openly practice FGM to others that already renounced FGM in Blue Nile and now are only aware of secret practices. It is noteworthy that in Doro Camp signs that FGM is no longer a social norm are present within communities though they are aware that their communities used to practice FGM they no longer believe it applies to them and that others are continuing the practice. Stories from different respondents have shown that FGM is no longer a precondition for marriage in all groups and those women are also aware of the dangers of FGM.

Nevertheless the information gathered also showed that there are serious disparities in knowledge of FGM between men and women while many women stated a stop in their practice as most men interviewed continued to stress that FGM was a normal practice. This incongruence goes on to show that lack of dialogue and public discussions on FGM might just be converting a previously public practice into a private one.

BATIL CAMP

Who, what, when and where?

The 2012 DRC Rapid Assessment on SGBV for Batil Camp mentioned that women interviewed and in focus group discussions had mentioned a high prevalence of FGM amongst the refugees (almost 100% of girls and women being mutilated) (DRC, November 2012).

Through interviews with health providers and respondent focus group discussions FGM was mentioned as an intrinsic practice for the refugees of Batil. The table below presents

COMMUNITY	Practiced FGM	Type	Age	Practitioner	Continued FGM practice
Ingassana	Yes	Type 3 - 1	>1 month	TBA	Yes – but some aware of effects
Magaya	Yes	Type 3-1	<6 years old	TBA	Slightly diminished
Jum Jum	Yes	Type 1	Infant	TBA	Yes
Others (Arabs)	Yes	Type 3	< 7 years old	TBA	Yes

Data collected from respondents is interesting as it shows two sides of the same story on the one hand a majority of Ingassana and Magaya respondents mentioned practising type 1 however others also mentioned practising type 3. Yet many respondents also mentioned that type 3 had been practised in Blue Nile but is no longer practised in Maban County. This also corresponds to data presented in the Sudan Health Survey (2006) mentioning a decrease in the practice of type 3 and an increase in practice of type 1.

It remains unclear though whether groups practising type 3 did start practising type 1 or simply just stopped practising FGM altogether though the latter is less likely as from different groups it was ascertained that FGM is a common practice in the camp.

In discussions with several groups there were only two instances where respondents mentioned stopping to practice FGM. One instance was related to the ethnic group of the Magaya that reportedly has decreased the practice of FGMA as they started being aware of the negative consequences of FGM already in Blue Nile State and have tried to stop the practice of FGM¹⁴. The other instance where respondents mentioned diminished practice of FGM were Ingassana women that had lived in Damazin who mentioned high levels of awareness raising and a decided campaign to stop FGM. These indicators would point towards a shift not according to ethnic group but more as dependant on whether respondents were previous urban or rural dwellers.

“FGM should be practised when the girls understand what is going on and why this is done.”(FGD with women)

As can be seen in the table above, one particular ethnic group within Batil Camp are women of what they termed ‘Arab’ descent (understood as tribes outside Blue Nile) that have married into ethnic groups of Blue Nile. Their families and communities practise infibulation and thus some of the women of Batil camp are infibulated. Women of this ethnic groups also practised re-infibulation (el-adel or re-tightening) and mentioned that in terms of re-infibulation women were facing issues as the TBA’s that normally practised this were not present in Maban County which was also mentioned by women of similar ethnicities in Doro Camp.

In all cases FGM is performed by either TBA’s or women that are especially trained (respondents mentioned each community might have between 2 to 3 women). Practitioners of FGM will always charge for the service though respondents mentioned several different prices. In general terms women mentioned that TBA’s will ask for soap, sugar, chickens and a monetary incentive that can go from 5 to 20 SSP per girl. Women respondents mentioned that husbands are involved in this stage of the practice as they will have to be the

¹⁴ Information from health providers in Batil Camp, 8th July 2013.

ones that pay for the service. If women’s husbands are not present then the women will request assistance from the husband’s family and in the worst case scenario if no family is present then from neighbours.

When discussing FGM with TBA’s in Batil they verified that normally it is a ‘special’ TBA that performs the FGM. They mentioned that normally there would be 3 or 4 women per community that had been specially trained by elder women/ special TBA’s back in Blue Nile. The TBA’s verified that the service is always paid and that payment depends on what the family collects but agreed that soap, food and livestock could be part of the payment. In terms of the FGM they mentioned that the procedure is done with a razor blade and that they would apply traditional herbs on the wound to help it heal additionally the baby would be confined to indoor spaces and kept alone to ensure that the wound did not get infected through contact with dust or other germs.

It is of interest that when asked whether a woman that had not been through FGM could get married women provided very diverse answers. In discussions with the TBA’s it became clear that all women had to have undergone FGM prior to marriage. If there was a case where the woman had not undergone FGM the mutilation had to be done before marriage otherwise the husband: *“would not like her or find her to be too smelly.”*¹⁵ This was not however the case with other women as they mentioned some instances in which girls were not mutilated mainly relating to health reasons, one woman mentioned that she knew a girl in her community who was not mutilated as: *“the father had refused for it to take place as the young girl had been very sick when born and he was afraid the FGM would make her even more sick.”*¹⁶ In relation to this case the women mentioned that the girls could avoid FGM even prior to marriage if the husband’s agreed to it, but that normally women would be pressured by her friends and peers and would normally end up agreeing to FGM to fit in with the rest and avoid being ostracised.

Why is FGM practised?

Reasons for FGM		
<p>HEALTH</p> <ol style="list-style-type: none"> 1) The clitoris will harm the baby during child birth 2) Infections are more likely without FGM 3) Germs can accumulate in the clitoris 	<p>TRADITION</p> <ol style="list-style-type: none"> 1) Practised for generations by women 2) Tradition has no explanation but must be continued 	<p>MARRIAGE</p> <ol style="list-style-type: none"> 1) Girls have to have gone through FGM for marriage 2) Women without FGM can only marry outsiders 3) FGM can also be practised at time of delivery

When discussing reasons with FGM with women it became apparent that many of the reasons given to them are subjective to their family and or community. Most of the women mentioned health as an important aspect as they had been told if FGM was not practised girls would be more susceptible to infections caused by germs. One TBA mentioned that: *“the clitoris had a hood and this is a dirty area as it cannot be cleaned properly, if FGM is not practised then the girls would have health problems”*¹⁷, they directly related issues that could affect males (circumcision practised as a health issue to allow for better access to cleaning) to females.

“Women that have not undergone FGM are not following the prescriptions of Islam and as such cannot even serve food during the Holy Month of Ramadan as they are not pure.”(FGD with women)

Only a few respondents mentioned religion in relation to FGM. It is noticeable that female respondents mentioned that FGM was part of being a good Muslim and was a direct prescription of the Quran.

¹⁵ Focus group discussion with TBA’s in Batil Camp, 17th of July 2013.

¹⁶ Focus group discussion with women in Batil Camp, 15th of July 2013.

¹⁷ Focus group discussion with TBA’s in Batil Camp, 17th of July 2013.

The men's perspectives on FGM

During discussions on FGM with men both older and younger men in Batil camp the most noticeable thing was their lack of information regarding what happened during FGM. Initially men were not able to answer most questions as to what happened, what type of FGM and effects. What was clear that FGM was a joint decision between the father and the mother though they did not provide any indication as to whether either party would ever deviate from the norm and challenge the practice of FGM. The three different ethnic groups (Jum Jum, Ingassana and Magaya) all confirmed the same idea that all women underwent FGM. When prompted with the different types men were able to confirm that the type which the women underwent was type 1 or 2 and that none of the three ethnic groups practiced infibulation, however it is important to make it clear that this only took place after quite extensive prompting on types of FGM. Men were not aware of any side-effects of FGM or of situations when the FGM had gone wrong and the girls had to be taken to the hospital.

When asked about reasons for performing FGM the men were as vague as with the types of FGM. Initially they were only able to mention health reasons and it was after probing that they mentioned religion (it is written in the Koran) and traditional practice as additions to health concerns. When asked on which specific health concerns the men were not able to answer. They mentioned that for boys they get small/invisible worms (could also possibly be they mean germs) if they are not circumcised, however when asked about girls they mentioned this did not happen to girls. Nevertheless, men mentioned issues regarding marriageability of girls as reasons for the continued practice of FGM (without prompts or probes). They mentioned that if girls did not undergo FGM they would not be able to marry they did present the parallel inversion and also mentioned that boys needed to be circumcised prior to marriage. It was very clear from what they mentioned that the issue of marriageability of girls was extremely important for them. Finally they also mentioned that women that had not undergone FGM were not pure as they were considered dirty and therefore again not appropriate for marriage.

Men confirmed what has been mentioned by other groups that girls undergo FGM when they approximately 7 days old. They also confirmed that TBA's are performing the FGM and that a small celebration is held some days after (perhaps a week after) the FGM has taken place. Men revealed that gifts are provided as part of the celebration mainly small amounts of cash that the parents would receive from relatives or neighbours. In some cases if the money was sufficient the parents would purchase livestock (mainly a small goat). The celebration would take place at the home, relatives and neighbours would be invited. The person performing the FGM would be invited to participate. The men were not able to state how much TBAs would charge they mentioned that: *"if you had some money you paid the money you had, if not then you gave her small gifts such as soap and if you had nothing you at least made sure she ate for free at your place..."*¹⁸ which would indicate that they are not involved in this aspect either, despite what women mentioned that men arranged the celebration.

Younger men mentioned that the only changes they had experienced since they arrived in Batil camp were the lack of funds to finance the party. They mentioned that while previously it was common to hear neighbours celebrating with music, dance and food now the FGM took place without the celebration as they did not have enough money to pay for this¹⁹.

On another note older men were interested in learning more about the potential harmful health consequences of FGM and mentioned that some awareness raising had started in Batil Camp though when asked specific questions they were not able to respond on what they had gained from the awareness raising. They did mention that they had never received awareness raising back in Blue Nile and that this was the first time they had started questioning whether FGM had negative consequences for the women. For younger

¹⁸ Focus groups discussion with men in Batil Camp, the 22nd of July 2013.

¹⁹ Focus group discussion with young men/youth in Batil Camp, the 24th of July 2012

men exposure to awareness raising was also non-existent and they did not even inquire as to potential health effects or issues related to FGM.

When asked about continuing the practice of FGM all men in Batil mentioned that they agree with FGM and they consider the practice as a good one that should continue. Some of the older men mentioned the practice in relation to marriageability which was also echoed by younger men.

Perspectives from Religious Leaders

Religious leaders in Batil Camp were adamant that FGM is not present in the Koran and is not a Muslim tradition the chief Imam of the camp mentioned that practice of FGM pre-dates the introduction of Islam into their communities and that there is no correlation between the religious practice of circumcision of boys and FGM. Leaders mentioned that FGM continues to be practised because stopping traditional practices is a long process and due to the fact that people do not understand why they should stop.

Imams mentioned that for some communities in Blue Nile doctors had done awareness raising on the health impact of FGM and imams had been involved in the awareness raising with communities in part to help dispel the myth that FGM was rooted in Islamic practice. In their eyes this sort of collaboration should continue as they feel that due to displacement discussions on FGM had stopped. Moreover religious leaders supported ideas of community dialogues though stressed the fact that issues related to FGM should be mostly targeted to women and facilitated by women.

What should happen with FGM? -Views of the respondents'

In general terms views of respondents across the board in Batil Camp considered that FGM is a normal practice that should continue to be practised by their communities an exception to this was women who had previously received awareness raising by NGO's within the refugee camp as they voiced concern at the continuation of this practice. The difference in notion between women who had been exposed and women who had not been exposed was markedly different while for all male groups the idea of continuing FGM was not even questioned.

In previous data collected by DRC it was revealed that over 90% of individuals and 81% of key informants believe that girls should undergo FGM and those few that think the practice should be discontinued is based their decision on possible complications during child birth for women with FGM (DRC, November 2012).

Findings clearly show that FGM is considered a social norm for the vast majority of the population in Batil Camp as they are aware that they should practice FGM and then know the rule applies to them. The extremely public nature of FGM ceremonies and the celebration that ensues is a sure way for all neighbours and peers to be aware that the family respects the practice which also means that families that might be tempted to not practice FGM would be under a lot of pressure from the extended relatives and peers.

GENDRASSA CAMP

In focus group discussions in Gendrassa it became apparent that FGM is also the norm in this camp. Both adolescent boys and girls and women confirmed that FGM is practised widely. However as the table below displays there are some disparities in the information regarding FGM:

WOMEN	GIRLS	BOYS
<ul style="list-style-type: none"> • Some practised Type 3 in Blue Nile but not in Maban County • Some started practising Type 1 once they started to stop Type 3 • Understand dangers with Type 3 but not with Type 1 • Practise FGM after 3 years old (up to adolescent years) • REASONS: Religious - FGM is prescribed in the Koran 	<ul style="list-style-type: none"> • FGM takes place when girls are infants (7 days old) • Most girls confirmed practise of Type 1 • Girls mentioned issues with FGM - infections, etc • REASONS: girls will not grow if FGM is not practised and girls will not be able to have children if FGM is not practised. 	<ul style="list-style-type: none"> • Aware FGM takes place • FGM takes place when girls are infants (7 days old) • Boys consider FGM as the same male circumcision - it is done for religious and hygienic reasons

It is significant to note that as per respondents views the type of FGM practised is not congruent as some women mentioned type 3 while other women and younger people mentioned type 1. This could partially be explained through the fact that previously type 3 had been the main type of FGM within several communities even if their ethnic counterparts in other communities practised type 1. This started changing in Blue Nile and as the women mentioned issues with deliveries of children and severe complications. A change from type 3 to type 1 fits the data presented in the Sudan Health Survey (2006) that mentioned that in the last 10 years a change from type 3 to type 1 was quite noticeable in Sudan.

“When FGM would happen all the boys and the men were sent away from the area” (FGD with boys)

As the study was not focusing on Gendrassa only 3 focus group discussions were held in this camp. Nevertheless the focus group discussions in Gendrassa shed light on a very important aspect of knowledge of girls and boys²⁰ related to FGM issues.

Gendrassa was the only camp where interviews with adolescents were possible and talking to a young group showed that for boys and girls issues relating to FGM and male circumcision were not discussed with younger people in the camps. Interestingly boys could recount extensive details of male circumcision but beyond the fact that FGM took place they had no idea what happened to the girls or the reasons for FGM. To rephrase it they were familiar with the outwards manifestation of FGM like the celebration that took place for girls but they were not familiar with other details. This gives an indication of why even older men have little knowledge of the actual practice of FGM, as well as details surrounding the practice, as it seems from adolescent respondents that little information about these practices is ever shared – when asked when they would be informed about FGM they mentioned that most men are not until after they were married. However, even then many of them remain very doubtful about the extent of the knowledge they have.

In a similar way adolescent girls had very little information about FGM – they were able to confirm that FGM was practised and basic information surrounding the practice of FGM. Although they were not aware about any details, they were able to recount incidents related to FGM practice and FGM and marriage issues:

²⁰

“A girl that had had no FGM practised because her father did not have enough money to pay the TBA, the girl had grown up and the girl had married (an outsider as a member of the community would not agree) but the girl was then subjected to FGM during her first child delivery”. (FGD with girls)

The above mentioned example, reveals the social pressure related to the practice. Although girls were able to get married without FGM, the practice would take place at some time because girls that had not undergone FGM would be pointed at and called names. . Other respondents also mentioned that girls that have not undergone FGM can marry only outsiders, as these men would not require FGM. Conversely they indicated that there had been some cases in Gendrassa where men had sent the women back to their parents’ homes if they had not undergone FGM

Discussions with women revealed that for the older group marriage without FGM is not an option – women were keen to emphasise that everyone in the community would know if a girl had not undergone FGM and that she and her family would be ostracised by the community: *“people would refuse to eat the food they had cooked or even drink water at the place of a girl that had not undergone FGM...”*²¹ Women also mentioned that this is why the celebrations relating to FGM were important in their communities – it made the community aware that the girl had undergone FGM and therefore the family could still be frequented. This information points towards a very important element – the public nature of FGM, which acts as a deterrent for stopping the practice due to the pressure the community can place on a single family.

Moreover when asked about reasons for FGM the adult women in Gendrassa were the only ones that adamantly mentioned religion as the only reason for FGM – though they clarified that though type 3 was not mentioned in the Koran, type 1 was indeed prescribed by Islam. The women mentioned that girls/women that had not gone through FGM could not pray, enter a mosque or come into contact with other Muslims. This sentiment was however not echoed by the younger girls who, as mentioned above, provided perceived health related reasons for FGM.

According to women, there are serious negative consequences for FGM for women that have undergone type 3 – women mentioned severe problems with child delivery, as well as higher infection rates and urine retention. However when asked about issues with type 1 FGM, women mentioned that there were none.

These same questions provided slightly different answers from girls – though when asked about consequences of FGM the girls mentioned that normally there were no consequences as traditionally the TBA’s would cure the wounds with herbs. Although they mentioned that cases could go wrong, they were not able to provide precise information about it.

“The TBA cut the girl and she could not urinate anymore. FGM was re-attempted on her afterwards 4 times until it worked. The girl was afraid and she ran away several times as she did not want them to keep trying...” (FGD with girls)

Perspectives on FGM were very similar to those of respondents of Batil Camp – FGM is a normal practice of their communities and they consider it a normal part of their lives. As in Batil Camp, it is clear that FGM in Gendrassa Camp is considered a social norm that has to be perpetuated. Though respondents are aware of the dangers of one type of FGM – namely type 3 – they do not consider the practice of FGM as such something that must stop. Clearly FGM is an ingrained practice and the public nature of the practice also ensures its continuation in the communities.

²¹ Focus group discussion with women in Gendrassa Camp, 7th of August 2013.

RECOMMENDATIONS FOR FUTURE PROGRAMMING

Due to the very different nature of the camps in terms of incidence of FGM as well as the ethnic groups, separate approaches are recommended to allow for a targeted approach that might have some impact. For the purpose of Gendrassa and Kaya recommendations for Batil could be implemented as the ethnic groups and incidence of FGM seems to be comparable.

"When I was a child we were wearing the skins of animals, we had no clothing. Then the Muslim missionaries arrived and told us we had to wash, practice hygiene and dress in jalabias. It took 7 years before we understood that perhaps wearing clothing and washing was good for us, imagine then how long it might take some people to understand that FGM is dangerous for them?" (FGD with Imams in Doro Camp)

A general word of caution: FGM is a sensitive topic that can provoke adverse reactions among the refugees. This however doesn't mean that the subject should not be addressed. Humanitarian organizations believe that protection and health actors could sensitize communities about the consequences of FGM and engage with them in a manner that allows them to dictate the speed of change. Otherwise, beneficiaries could end up opposing NGOs prescriptions and

potentially turn to practising FGM in secret.

DORO CAMP

The study showed that diverging practices in Doro provide a unique possibility to work with FGM prevention and awareness. Due to previous campaigns in Blue Nile state and some awareness raising in Doro Camp the population is first of all much more willing to discuss the subject, has diverging practices – a situation that can be capitalised on, and finally have a basic level of knowledge relating to FGM that can allow for a further push for change.

Nevertheless this diversity of practices is also potentially a double-edged sword – as multiplicity of practices could mean that more secretive approaches are favoured and the practice continues to practice FGM without public knowledge and as such without avenues for recourse. To try and avoid a shift to communities moving towards internal and secret practices a three pronged phased approach is recommended.

- 1) Keep informing the people- target the information carefully: Awareness raising is highly recommended for Doro Camp both to communities that have significant information on the practice and to those that have little information.. These messages should be targeted carefully and tailored to each audience given that FGM has been discussed with many groups in Blue Nile and the practice has become less prevalent..

Populations that have already received information might find it patronising to receive the most basic information. In discussions with beneficiaries in Doro Camp it became apparent that what people want is to discuss specific issues – for example detailed information on health issues surrounding delivery of children and FGM. Women in one community expressed interest when in one question and answer session (after the focus group discussion) the facilitator discussed fistula and the relation of fistula to FGM, as well as how to deal with fistula. This is just an example of a topic but points towards a more targeted awareness raising that focuses on different issues each time.

It is recommended to start with the medical issues as they are easier for everybody to understand and normally have the highest impact on beneficiaries. In many cases respondents mentioned a decrease in FGM as doctors in Blue Nile had done advocacy on the issues due to the severe medical complications. Additionally it could be of added value to include training on awareness raising of such issues for TBA's, as they have regular contact with women, and they could be open to discussing issues of FGM with women they are checking on regularly.

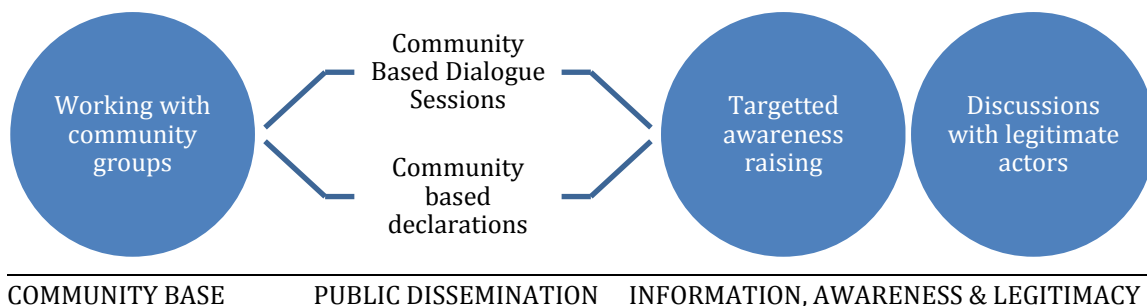
Awareness raising on FGM topics should always be keep separate between men and women (boys and girls) due to the cultural practices attached to the topic. However, this does not mean that

awareness sessions should not be held with men, but sessions for men and youth should emphasise negative health effects, which is not such a controversial way to start re-introducing the topic into men's and boy's groups.

Initial awareness raising, based on health effects, should be conducted in smaller groups (whether for women or for men) to try and make participants comfortable and not expose them to feeling ashamed for discussing issues like these publicly. Though materials (leaflets, brochures) might have an impact, it is again important that messages are targeted carefully and taking into account cultural sensitivities when it comes to sexual issues. Additionally leaflets and brochures should not be publicly displayed as this will just cause consternation without dialogue, but should instead be provided to those attending sessions for further private reading in their homes or for more localised discussions within their family.

Once rapport has been established and respondents are aware of all the health side effects it would be important to start discussing FGM from a rights perspective. This will be extremely challenging as knowledge of rights in general is very low in the refugee population. Campaigns focusing on rights awareness should be conducted with traditional authorities (the sheikhs and umdas) that command enough legitimacy to allow for communities to discuss the issues as well be able to act on them. The impact of having sheikhs and imams help discuss these issues will be higher.

- 2) *Capitalise on existing groups – expand and refine:* discussions around FGM related issues should be part of group discussions within the camp. Formal but particularly informal groups might provide excellent platforms for safe discussion – especially for women. Some of the more successful interventions in other African countries have been based on women's groups. It is recommended that a preliminary mapping is done initially to ascertain the actual extent of both more formal and informal groups and then these groups are provided awareness raising and discussion opportunities. Working with the groups will not deliver quick impact but will allow discussion at a pace in which beneficiaries can keep up while helping create bonds between the group members which might be needed later on when more action oriented interventions are needed. For example it would be important to understand how informal education groups function, what is their scope across the camp and how they can be strengthened. An education setting would be helpful as a platform for providing messages to beneficiaries that clearly eager to learn.
- 3) *Community based dialogue – and potentially community based declarations:* once the first two recommendations are underway this third recommendation can be considered, targeting traditional authorities that might be able to ensure a consistent and sustainable change; traditional authorities in all camps would include the sheikhs and umdas and the religious leaders. This third recommendation aims at a two-step process: first communities dialogues are organised to discuss issues surrounding FGM. If groups (as mentioned above) have been strengthened they can provide the basis for the discussions in their communities. As with any sensitive intervention in the camp, it is important that the traditional leaders are involved from the beginning, as they will legitimise the discussions and allow people to participate in these without feeling they will later face consequences from their own communities. The process needs to be open and transparent, and traditional leaders are able to legitimise it from the beginning allowed issues to be voiced publicly.
- 4) The diagram below tries to capture the two pre-requisites for the dialogue sessions and the community based declarations.

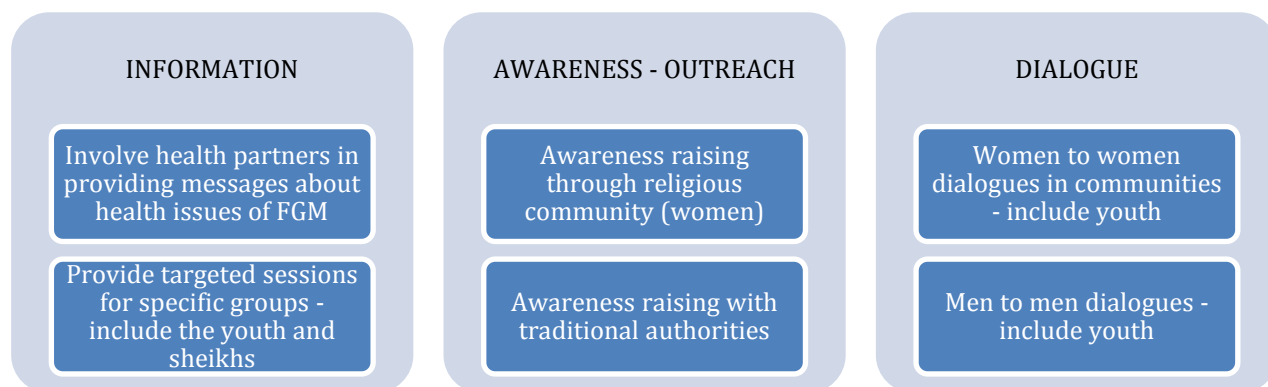


Community based dialogues should eventually pave the way for community based declarations – public declarations made by communities pledging to stop FGM in their community/ethnic group as well as make sure FGM is not a pre-requisite for marriage of girls. It is expected that community based dialogues will provide forums for communities to discuss issues related to FGM but also be able to make a stand against FGM. Once a critical mass of people has been reached through dialogues groups can push for a community based declaration – which makes efforts publicly known and thus also create more dialogue and discussion within the communities. Due to the potential for continuing FGM in secret community based declarations make an otherwise more private discussion public. Moreover if communities pledge to allow women without FGM to get married – and the family of boy’s pledges then little incentive is left for the practice of FGM, as well as providing a safe way for families to stop practising FGM – they no longer have to worry about FGM as a pre-requisite for marriage of their daughters.

BATIL CAMP

From the information collected for Batil Camp it becomes clear that the approach suggested for Doro Camp would not necessarily work as the levels of awareness regarding FGM issues are much lower – this is also valid for Gendrassa Camp. Therefore a more information and awareness focus is recommended for Batil Camp.

In general terms the basic strategy for working with FGM in Batil Camp should focus on awareness raising through different methods and targeting different population groups. The table below shows the three modes of action for initial programming in Batil camp:



- 1) Information campaigns: as with Doro Camp it is important to involve health actors in providing information on health consequences of FGM as an initial point to try and get beneficiaries involved in talking and thinking about FGM as something else than the norm. Again knowledge of rights is extremely low thus it is best to try and focus on tangible issues as an entry point and then move to rights- information when communities are more comfortable with discussing issues such as FGM.

Additionally in this phase it is also very important to provide targeted sessions for duty bearers – such as religious and traditional authorities where FGM is clearly discussed. As some of the religious leaders have had awareness raising in Blue Nile it would probably be beneficial to mix religious and traditional leaders together as they can discuss issues at the same level.

- 2) Awareness outreach sessions/ campaigns: during discussions with religious leaders it became apparent that through their previous experience with awareness raising in Blue Nile this group could work towards stopping FGM. The religious leaders themselves suggested that religious women (Fakiras) that already work in the mosques could be used to provide outreach services in communities. It is important that once awareness moves out into the communities it works through community – based structures that are seen as legitimate.

Providing awareness raising for sheikhs and using sheikhs to do awareness raising is key to trying to catch all groups within the awareness raising – particularly the men. This phase is an extension of the previous one – as sheikhs learn and start discussing FGM it is important that they also pass on the knowledge and the discussion to their communities, targeting the men and the youth in their communities.

- 3) Dialogue within and across communities: this step is intended to continue the work already started through information sharing and awareness raising in communities. This step is recommended as it allows communities to discuss issues at their own pace and in their own ways. The ideal way would be to work through women and men in communities that have already had extensive awareness on FGM and are able to motivate others to discuss the issues. As above the Fakiras could be utilised for this, but also other resource women could be utilised – ones that are also able to effectively include youth in debates and discussions.

In trying to stimulate as much dialogue as possible it would also be beneficial to have mixed groups – mixed ethnic groups that are able to discuss differences between their groups but also understand how they can support each other. Community dialogue (women to women and men to men) should also stimulate stronger bonds between groups, and allow youth to access information and knowledge that can be then discussed separately by themselves in youth groups. It became apparent through the study that youth – both male and female – have very little access to information and would not be able to question practices as they barely understand the actual practice itself – providing information to this group might prove to have positive impact for potential decrease of FGM practices.

- 4) Information dissemination – sharing experiences: once communities and duty bearers are more open to discussing the issue of FGM it is extremely recommended that there is an exchange between communities of Doro and Batil Camps. Particularly due to the ethnic affiliations – there are Ingassana in both camps, it would be beneficial to have the religious and traditional leaders of camps meet and discuss the issue of FGM. The different experiences will complement work done previously – awareness raising and community dialogues and might lead change that is more engrained in the whole group and transmitted across generations. Exchange between the camps will also allow for groups like the Ingassana to discuss with segments of their communities that perhaps they have not been in contact with before – for example urban and rural differences – and these dialogues might provide a good stepping stone to further eradication of FGM in the community as a whole.

REFERENCES

- Abdel Magied, A and Sulima, E. and Kawther, D. 2000. "Re-Circumcision: The Hidden Devil of Female Genital Mutilation. Case Study on the Perception, Attitudes and Practices of Sudanese Women." *Afghad Journal*, Vol 17, No 1. June 2000.
- Abdel Magied, A and Musa Ahmed, S. 2002. "Sexual Experiences and the Psychosocial Effect of Female Genital Mutilation (FGM) or Female Circumcision (FC) on Sudanese Women." *Atlantis: A Women's Studies Journal*. FKN Special Issue one (reproduced with permission from: *The Afghad Journal*, Vol 19, No.1, June 2002.
- Almroth, L. 2005. "Genital Mutilation of Girls in Sudan. Community – and hospital- based studies on female genital cutting and its sequelae." Department of Public Health Sciences, Division of International Health (IHCAR), Karolinska University Press, Stockholm, Sweden.
- Almroth L, et al. 2005. "Primary infertility after genital mutilation in girlhood in Sudan: a case-control study." *The Lancet*, Vol 366, July 30 2005. Pp. 385-91.
- Behrendt, A. February 2011. "Listening to African Voices. Female Genital Mutilation/Cutting among Immigrants in Hamburg: Knowledge, Attitudes and Practice." Plan International Deutschland e.V.
- Berggren, V. 2005. "Female Genital Mutilation, Studies on primary and repeat female genital cutting." Karolinska University Press, Stockholm, Sweden.
- Berggren, V. et al. August 2006. "Being Victims or Beneficiaries? Perspectives on Female Genital Cutting and Reinfibulation in Sudan." *African Journal of Reproductive Health* Vol 10. No 2. Pp. 24-36. Published by Women's Health and Action Research Centre (WHARC).
- Danish Refugee Council. July 2012. "A Sexual and Gender Based Violence Rapid Assessment Doro Refugee Camp". Upper Nile State, South Sudan.
- Danish Refugee Council. September 2012. "A Sexual and Gender Based Violence Rapid Assessment Jammam 2 Refugee Camp". Upper Nile State, South Sudan.
- Danish Refugee Council. November 2012. "A Sexual and Gender Based Violence Rapid Assessment Batil Refugee Camp." Upper Nile State, South Sudan.
- Hashi, K and Sharafi, L. 2007. "A Holistic Approach to the Abandonment of Female Genital Mutilation/Cutting." UNFPA Technical Report. From: www.unfpa.org/public/pid/407
- Hollway, W and Jefferson, T. 2000. "Doing Qualitative Research Differently: Free Association and the Interview Method." SAGE Publications.
- Landinfo Report. December 2008. "Report: Female Genital Mutilation in Sudan and Somalia." Publication number 764 (consulted on the 19th of July 2013).
- Mackie, G. 2000. "Female Genital Cutting, The Beginning of the End" in Shell-Duncan and Herlund (eds), "Female Circumcision: Multidisciplinary perspectives". Boulder CO: Lynne Rienner Publishers. Pp. 245-282
- Mazharul, M and Mosleh Uddin, M. 2001. "Female Circumcision in Sudan: Future Prospects and Strategies for Eradication." *International Family Planning Perspectives*, Volume 27, Number 2, June 2001.
- Republic of Sudan. May 1991. "Sudan Demographic and Health Survey 1989/1990." Department of Statistics, Ministry of Economic and National Planning, Khartoum, Sudan and Institute for Resource Development /Macro International Inc., Columbia, Maryland, USA.

Republic of Sudan. 2006. "Sudan Household Health Survey (SHHS) and Millennium Goal Indicators (MDG). Summary Table of Findings." Ministry of Health and the Central Bureau of Statistics of the Government of National Unity and the Ministry of Health and the Southern Sudan Commission for Census Statistics and Evaluation of the Government of Southern Sudan. From: <http://www.irinnews.org/pdf/pn/shhsreport.pdf>

Shell-Duncan, B. et al. 2010. "Contingency and Change in the Practice of Female Genital Cutting: Dynamics of Decision Making in Senegambia." Summary Report.

Shell-Duncan, B et al. 2011. "Dynamics of change in the practice of female genital cutting in Senegambia: Testing predictions of social convention theory." *Social Science and Medicine* xxx (2011) Pp 1-9

Toubia, N. 1994. "Female Circumcision as a Public Health Issue". *The New England Journal of Medicine* (Special Article). Sept 15, 1994. Downloaded from: nejm.org on June 26th 2013.

United Nations Population Fund (UNFPA)- A Technical Report. 2008. "Global Consultation on Female Genital Mutilation/Cutting." Report prepared by Gender, Human Rights and Culture Branch, Technical Division. From: www.unfpa.org/webdav/site/global/shared/2008/fgm_2008.pdf

United Nations High Commissioner for Refugees (UNHCR).1997. "The How to Guide Reproductive Health in Refugee Settings: from Awareness to Action. Pilot Project to Eradicate Female Genital Mutilation." Hartisheikh, Ethiopia, December 1997 (final draft).

United Nations Children's Fund (UNICEF). July 2013. "Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change." From: http://www.unicef.org/media/files/FGCM_Lo_res.pdf (consulted on the 23rd July 2013)

World Health Organisation (WHO). 2007. "WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies." From: www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf

World Health Organisation (WHO). February 2013. "Female Genital Mutilation" Fact Sheet No241. From: <http://www.who.int/mediacentre/factsheets/fs241/en/> (consulted 5th of August 2013).